

**SURVEY OF  
ADMINISTRATIVE OPERATIONS  
IN  
NAVAL HOSPITALS**















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in

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1 October 1947







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Rear Admiral C. A. Swanson, (MC) USN  
Bureau of Medicine and Surgery  
Washington, D. C.

Dear Admiral Swanson:

The survey of administrative operations of five representative naval hospitals has been completed, and the report is submitted herewith. The hospitals studied were those at Portsmouth, Virginia; Philadelphia, Pennsylvania; Great Lakes, Illinois; San Diego, California; and Newport, Rhode Island. This is a composite report of these five hospitals and includes a factual recording of actual conditions and practices, an appraisal of specific strengths and weaknesses, and a series of recommendations for the improvement and standardization of hospital organization, management, and procedures.

Individual reports listing findings and recommendations concerning local conditions were not prepared for each hospital. At the completion of each hospital study, however, we held a lengthy conference with the medical officer in command, the executive officer, and the administrative assistant for a general discussion and a summary of our findings. At these conferences, specific recommendations were made, occasionally, which tied in with the general purposes of the survey, and could be applied immediately to local management problems.

We were extremely fortunate to be able to discuss in considerable detail the various recommendations submitted in this report with many capable Medical Corps, Dental Corps, Nurse Corps, and Hospital Corps officers. These discussions were of great value in helping us crystallize our ideas. Many ideas expressed in sections of this report represent the majority opinion of key hospital personnel, and are not primarily those of the analysts.

Generally, the officers with whom we talked recognized a real need to reshape and standardize administrative operations within hospitals without delay, and were pleased to know that the Bureau was taking positive measures to work closer with the hospitals in ascertaining existing problems and attempting to institute the necessary improvements. These men were interested in the development and installation of a field program which will gear operations to postwar requirements.



Unfortunately, many of the operating personnel felt that the Bureau was not aware of, or did not have much interest in, field problems. They did not know how things were done in the Bureau or, in many cases, why they were done. This feeling that the Bureau has little concern for the internal problems of the hospitals is a serious matter, and one which should not be passed off lightly. As long as this feeling exists, optimum results can not be achieved. Constant liaison should be maintained between the Bureau and its field activities, not only at the top management level but, even more important, at the operating level. It would be extremely advantageous to the Medical Department if personnel from the several operating divisions within the Bureau made periodic trips to the field activities to work jointly with field personnel in a common effort to "find the right answer."

During the entire course of the survey, we received excellent cooperation and assistance from both military and civilian personnel. Many of these people advanced ideas which were of real value to us in this work.

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## INTRODUCTION

### BACKGROUND

The rapid expansion of naval hospital facilities during the war resulted in the adoption of numerous emergency administrative measures and procedures, many of which varied from hospital to hospital. During the war period emphasis was placed entirely on the professional services. These services were reviewed constantly so that the latest advancements in medicine and surgery could be continuously applied. It was the policy of the Bureau to introduce as few changes in administrative practices as would be consistent with the effective conduct of the war.

As a result of the policy of allowing the adoption of individual administrative measures, as necessary, and delaying longer-range economies in administration which would apply to all hospitals, many cumbersome and often unrelated operations were established. Various hospitals were performing the same task differently; consequently, in many phases of hospital administration there was little or no standardization. The Bureau recognized this situation, and realized that standardization could be achieved only from the Bureau level. Therefore, as a normal development in the transition period between wartime and peacetime hospital administration, the Bureau of Medicine and Surgery initiated a survey of the administrative practices in naval hospitals.

### PURPOSE

The purpose of this survey is to increase the effectiveness of the hospital function by improving and standardizing the organization and major non-professional procedures in naval hospitals. The purely professional aspects of hospital operations were not emphasized.

### APPROACH

The survey was initiated with no preconceived findings. It was factual and objective. The survey team made a thorough fact-finding study at five representative hospitals, and prepared this final report listing recommendations for naval hospital administration. The hospitals studied were Portsmouth (Virginia), Philadelphia, Great Lakes, San Diego, and Newport. These hospitals were selected on the basis of their comparability, particularly in regard to patient census, types of patients treated, type of construction, and local problems. Portsmouth, Great Lakes, and Newport are comparable in most respects, and



San Diego is quite similar to Philadelphia. During the fact-finding period of the survey, the highest possible degree of comparability between activities studied was considered to be of major importance.

#### METHOD

The team held an initial conference with the medical officer in command, the executive officer, and the assistant to the executive officer (administrative) immediately upon arriving at a hospital. The nature and purpose of the survey were explained in detail, and the hospital officials' views of specific management problems requiring special attention were obtained. At the conclusion of each study, a final conference was held with the same officers to summarize and discuss the findings of the survey team.

Each organizational unit was reviewed thoroughly, including the administrative aspects of each professional service. Most of the time was spent in the activities which perform the bulk of the administrative work, i.e., the personnel and records, finance, commissary, and maintenance divisions. In each unit an analysis was made of the following factors:

1. Mission and Degree of Accomplishment: The coordination between organizational units with respect to the accomplishment of the main objective of the hospital.
2. Organization: The size of unit, type and amount of supervision, functional breakdown, distribution and necessity of functions, and delegation of authority and responsibility.
3. Personnel: The civilian and military personnel management functions, job analysis, grade relationships, training, personnel attitudes, working relationships of military and civilian personnel, and method of complement control, including coordination of military and civilian personnel requirements.
4. Procedures and Standing Orders: The major administrative procedures, work distribution and work flow, and correspondence and files.
5. Reports, Records, and Forms: The number of reports required, possible consolidation or elimination of reports to avoid duplication and unnecessary work, method and time for compilation, use of standard forms, use of local forms, and reports and forms control.
6. Work Measurement and Staff Requirements: The determination of work load indicators, the development and application of work load standards, and the determination of the staff requirements for each organizational unit based on the patient load.

## ORGANIZATION

The team stressed the analysis of the effectiveness of hospital organization as outlined in the Manual of the Medical Department, and the degree to which the hospitals observed this outline. In addition, consideration was given to the need for standardizing the internal organization of major administrative divisions, and the adequacy of the delegation of responsibility.

## PROCEDURES AND REPORTS

All administrative procedures were reviewed but, in view of time and personnel limitations, the team concentrated on a detailed study of methods and procedures in the records and personnel divisions only. The magnitude of the record-keeping problem at all naval hospitals emphasized the need for spending considerable time on this major aspect of hospital administration. Approximately 50 people were employed in the records divisions at Philadelphia alone, at a total annual salary of \$125,000. Proposed standard staff and patient records procedures are included in this report.

No attempt was made to develop detailed procedures for the commissary and maintenance divisions. Since only a few employees were involved, it was doubtful if the effort would be justified. Standardization of procedures in the finance division was not attempted either, although a considerable number of people are employed in this division. Fiscal procedures are closely controlled either by Bureau of Supplies and Accounts specifications, or requirements laid down by the Finance Division of the Bureau of Medicine and Surgery. The standardization of hospital finance procedures can best be worked out in close cooperation with Finance Division personnel in the Bureau.

Outlines and flow charts of the basic procedures in use were prepared as a basis for the proposed procedures; and detailed operational steps, including data on the preparation of standard and local forms and the compilation of reports, were recorded. Individual procedures were analyzed for their effectiveness and comparisons were made with procedures used in other hospitals. Standard procedures were then recommended on this basis.

## PERSONNEL

Personnel administration problems were studied not merely in terms of principles, but in the dollars and cents cost to the Bureau as reflected in the improper utilization of pay grades and lower output per worker. The scope of the required personnel program is recom-



mended, and the ways and means of implementing such a program are suggested in this report.

#### WORK MEASUREMENT

The primary purpose of the work measurement aspect of the survey is to reveal the effectiveness of personnel performance not only for each hospital as a whole, but for each organizational unit as well. Effectiveness is revealed by the comparison of the number of man-hours actually required to perform the work and the number which should have been required according to predetermined standards. As a result, the Bureau of Medicine and Surgery will be in a position to evaluate the performance of each individual hospital and, at the same time, compare the performance of all hospitals with each other for effective complement control.

The survey has indicated that personnel costs represent about 75 percent of the total costs of hospital operations, and therefore, that staff requirements are the best indicators of hospital costs. For this reason, considerable emphasis has been placed on personnel requirements.

One of the by-products of the work measurement and work standards study is the development of curves showing the total staff requirements at various patient loads for each hospital.

#### GENERAL

All broad, general statements concerning hospitals or hospital administration which are made in this report refer to the five hospitals studied.

## CONTENTS

	<u>Page</u>
LETTER OF TRANSMITTAL	111
INTRODUCTION	v
I SUMMARY OF RECOMMENDATIONS	1
II ORGANIZATION OF NAVAL HOSPITALS	27
III PERSONNEL ADMINISTRATION	39
Military Personnel	41
Civilian Personnel	45
IV WORK MEASUREMENT AND STAFFING REQUIREMENTS	61
V ADMINISTRATIVE DIVISIONS	117
Personnel and Records Divisions	119
Admission Unit	129
Bureau of Medicine and Surgery Section	139
Bureau of Naval Personnel Section	151
Military Personnel Section	166
Bag Room	170
Miscellaneous Services	173
Finance Division	177
Disbursing Office	189
Maintenance Division	195
Laundry and Linen Room	207
Transportation Section	219
Power Plant	227
Shops and Grounds Section	230
Janitorial Service	244
Commissary Division	245
Security and MAA Division	261
Staff Quarters	271
Medical Library	273
Office Services	275



	<u>Page</u>
VI PROFESSIONAL SERVICES	281
Surgical Service	283
Dental Service	289
EENT Service	297
X-Ray Service	301
Laboratory Service	309
Pharmacy Service	317
Ward Administration	319
Dependents' Service	339
Rehabilitation Service	347
VII FOLLOW THROUGH	353
APPENDIX I: PROPOSED STANDARD PROCEDURES FOR WARDS AND PERSONNEL DIVISION	357
APPENDIX II: EXHIBITS AND TABLES FOR INDIVIDUAL HOSPITALS	427
 <u>TABLES APPEARING IN TEXT</u>	
1. Typical Work Load Indicators	85
2. Percentage Distribution of In-patients by Services	86
3. Proposed Staff Requirements for a Standard Naval Hospital	87
4. Proposed Staff Requirements for Portsmouth	88
5. Proposed Staff Requirements for Philadelphia	89
6. Proposed Staff Requirements for Great Lakes	90
7. Proposed Staff Requirements for San Diego	91
8. Proposed Staff Requirements for Newport	92
9. Total Staff-per-Patient Ratio - Past Performance	93
10. Medical and Dental Officers per Patient - Past Performance	94
11. Excess Staff in Five Naval Hospitals Compared with Proposed Standard Staff Requirements	95
12. Percentage Distribution of Total Staff in Five Naval Hospitals	96
13. Percentage Distribution of Corpsmen in Five Naval Hospitals	97
14. Comparison of Proposed Standard Staff Requirements with Average Past Performance	98
15. Personnel Requirements for Personnel and Records Division by Functional Units	126
16. Proposed Standard Staff Requirements for Personnel Division	127

	Page
17. Personnel and Patient Records - Past Performance	128
18. Proposed Standard Staff Requirements for Finance Division	186
19. Past Performance in Finance Divisions	187
20. Proposed Standard Staff Requirements for Disbursing Office	192
21. Past Performance in Disbursing Offices	193
22. Proposed Standard Staff Requirements for Laundry Operation	217
23. Pieces of Laundry per Worker - Pieces of Laundry per Patient	218
24. Proposed Standard Staff Requirements for Transportation Section	225
25. Miles per Patient - Miles per Staff per Month	226
26A. Shops and Grounds Personnel - Present Complement by Grades (all hospitals)	236
26B. Utilization of Grades - Shops and Grounds Section, Portsmouth, Va.	237
27. Number of Work Repair Requests per Million Square Feet	238
28. Work Repair Requests Completed per Worker	239
29. Shops and Grounds Personnel per Million Square Feet	240
30. Square Footage per Patient in Maintenance Divisions	241
31. Proposed Standard Staff Requirements for Shops and Grounds in Individual Hospitals	242
32. Proposed Standard Staff Requirements for Shops and Grounds Sections	243
33. Distribution of Civilian Non-IVb Workers by Grades in Commissary Divisions	256
34. Distribution of Staff by Functional Units in Commissary Divisions	257
35. Proposed Staff Requirements for Individual Hospitals (Commissary)	252
36. Proposed Standard Staff Requirements for Commissary Division	258
37. Staff Employed per Ration in Commissary Divisions - Past Performance	259
38. Proposed Standard Staff Requirements for Security and MAA Division	269
39. Past Staffing of Master-at-Arms Forces	270
40. Proposed Standard Staff Requirements for Main Operating Room	286
41. Operations per-Staff-per-Month in Main Operating Rooms	287
42. Operations per-Patient-per-Month in Main Operating Rooms	288
43. Proposed Standard Staff Requirements for Dental Service	295
44. Sitzings per Staff - Sitzings per Patient for Dental Services	296
45. Proposed Standard Staff Requirements for EENT Service	299
46. Sitzits per Patient - Sitzits per Staff for EENT Services	300



	<u>Page</u>
47. Proposed Standard Staff Requirements for X-Ray Service.	305
48. X-Ray Examinations per Patient per Month	306
49. X-Ray Examinations per Staff	307
50. Proposed Standard Staff Requirements for Laboratory Service	313
51. Laboratory Tests per Patient per Month	314
52. Laboratory Tests per Staff per Month	315
53. Proposed Standard Staff Requirements for Nurses	327
54. Past Performance of Nurses in Five Hospitals	328
55. Proposed Standard Staff Requirements for Ward Corpsmen	329
56. Proposed Total Nursing Staff	329
57. Past Performance of Ward Corpsmen in Five Hospitals	330
58. Proposed Standard Staff Requirements for Dependents Service	345
59. Staff per In-patient Ratio for Dependents Services	346

#### EXHIBITS APPEARING IN TEXT

1. Proposed Organization Chart for U. S. Naval Hospitals	28
2. Present Organization Chart - Philadelphia	36
3. Present Organization Chart - Portsmouth, Va.	37
4. Standard Personnel Record Card	60
5. Total Staff Required for Five Hospitals - Present and Proposed	63
6. Staffing Curves - Average of Five Naval Hospitals	99
7. Staffing Curve for U. S. Naval Hospital, Portsmouth, Va.	101
8. Staffing Curve for U. S. Naval Hospital, Philadelphia	103
9. Staffing Curve for U. S. Naval Hospital, Great Lakes	105
10. Staffing Curve for U. S. Naval Hospital, San Diego	107
11. Staffing Curve for U. S. Naval Hospital, Newport	109
12. Distribution of Corpsmen between Administrative Divisions, Wards, and Other Clinical Services	65
13. Comparison of Costs in Operating Two Hospitals vs. One Hospital at the Same Total Patient Load	111
14. Recommended Distribution of Total Patient Load between Two Sample Hospitals of Different Overhead for Minimum Staff Requirements	113
15. Suggested Modifications of Expense Analysis Register	115
16. Proposed Organization Chart for Personnel Division	118

	<u>Page</u>
17. Proposed Standard Admission Card	133
17A. Distribution of Proposed Standard Admission Card	137
18. Recommended Organization of Maintenance Division at 1200 Patients	201
19. Recommended Organization of Maintenance Division at 600 Patients	203
20. Comparison of Present and Proposed Organization of Maintenance Division at Portsmouth, Va.	205
21. Ratio of Nursing Staff to Patient - Present and Proposed	331
22. Distribution of Nurses between Wards, Dependents Service, and other Services	333
22A. Distribution of Corpsmen between Wards, Clinical Services, and Administrative Divisions	335
23. Nursing Requirements for Service Patients vs. Dependent Patients	337





I SUMMARY OF RECOMMENDATIONS





## SUMMARY OF RECOMMENDATIONS

The recommendations contained in the text of the report are summarized below under the four major groupings employed throughout the report:

Organization

Personnel Administration

Methods and Procedures (including Reports and Forms)

Work Measurement and Staffing Requirements

In addition, certain recommendations pertaining to physical layout have been included.

Each recommendation is cross-referenced by page number to the body of the report which contains findings and interpretations on which the recommendation is based.

### ORGANIZATION

- |  | Page |
|--|------|
| 1. The current organization chart for naval hospitals which appears in the Manual of the Medical Department (paragraph 16A5.2) should be modified and replaced by the proposed organization chart, Exhibit 1. The new chart should be supplemented by functional statements which clarify the responsibilities of each administrative division and professional service. | 29   |
| 2. The officer of the day should be shown on the organization chart as being responsible for all hospital operations during the hours from 1630 to 0800 the next morning.  | 32   |
| 3. The position of Assistant to the Executive Officer (Professional) should be abolished. The chiefs of all professional services should report directly to the Executive Officer.   | 30   |
| 4. The functions of the Assistant to the Executive Officer (Administrative) should be clearly defined to show, in particular, line authority over the administrative divisions. The title of this position should be changed to "Administrative Officer."  | 30   |



5. A management engineer position as staff advisor to the commanding officer should be established at the largest hospitals to devote full time to hospital management problems both in the hospital to which he is attached and the other hospitals in the area. 33
6. All personnel functions, including record keeping for patients, military staff, and civilian staff, should be consolidated in the Personnel Division. The Records Division should be abolished as an organizational unit. Organizationally the Personnel Division should include:
- a. Admission Unit.
  - b. Bag Room.
  - c. Military Personnel Section, including maintenance of military pay data, liberty, and patient details.
  - d. Civilian Personnel Section.
  - e. Information Desk.
  - f. Mail Directory Service.
  - g. Central Files.
  - h. Civil Readjustment. 119
7. To perform its prescribed functions as outlined in the Manual of the Medical Department, paragraph 1511, the Finance Division organization should be standardized to consist of a Procurement Section, an Accounting Section, a Payroll Section, and a Stores and Equipment Section directly responsible to the finance officer. Where a civilian position of full-time administrative assistant to the Finance Officer currently exists, it should be abolished. When necessary, the civilian in charge of one of the sections, usually the Accounting Section, should act in this capacity. 178
8. The Disbursing Officer and the Ships Service Officer should be responsible to the Administrative Officer, rather than the Executive Officer as prescribed by the Manual. 189
9. The Maintenance Division for hospitals of 1200 patients and 600 patients respectively should be established according to Exhibits 18 and 19, particularly with regard to the number and relationships of supervisory personnel. One officer, preferably a Civil Engineer Corps officer, should have full responsibility for all maintenance functions. The following functions should be included:

- a. Maintenance office force.
- b. Laundry, including central linen room.
- c. Transportation, including machine shop.
- d. Power (or heating) Plant.
- e. Shops and Grounds.
  - Carpenter Shop.
  - Plumbing Shop.
  - Electrical Shop.
  - Paint Shop.
- f. Grounds Force.
- g. Janitorial force, including supervision of patient and staff details on cleaning duties.
- h. Elevator Operators.

195

10. The Maintenance Division rather than the master-at-arms, should be fully responsible for the cleanliness of all buildings and grounds except those areas normally considered the responsibility of a particular division or service.

244

11. The technical aspects of the safety function should remain as a collateral duty of the Maintenance Officer; but the clerical aspects, including records and reports, should be reassigned to the Personnel Division. Close collaboration between the two divisions in all matters pertaining to safety will be necessary.

196

12. A billet should be established in the medium and large hospitals for a Hospital Corps officer as chief of the Security and MAA Division. He should report to the Executive Officer, and be responsible for the chief master-at-arms, civilian and military guard force, fire department, for brigs and disciplinary matters, and legal affairs.

262

13. The administration and assignment of patients to work details should be the responsibility of the Hospital Corps detail desk in the Personnel Division rather than the Security and MAA Division, so that the necessary coordination with the assignment of enlisted staff personnel can be effected.

262

14. Hospital fire departments should be eliminated where adequate service is provided by adjacent naval activities and municipal civilian fire departments.

265



	Page
15. The Special Diet Kitchen should be administratively responsible to the Commissary Officer instead of the Chief Nurse.	245
16. Separate nurses' messes should not be operated for less than 40 nurses or where more than one commissary worker would be required for every five nurses.	245
17. The medical and recreational libraries should be located in adjoining spaces, and under the combined supervision of a professional librarian, who is responsible to the Administrative Officer.	274
18. Miscellaneous office services, such as telephone, communication, mimeograph, photostat, office supply, and messenger activities, should be consolidated in a single unit, called "Office Services", which will be responsible to the Administrative Officer.	275
19. Educational services for discharges now being conducted by the Education Office should be assumed by the Veterans Administration representative. Educational services for active duty corpsmen should be transferred to the Welfare and Recreation Division.	349
20. Civil Readjustment should be the responsibility of the personnel officer, with assistance from the Veterans Administration representative.	350
21. The Postal Division should be eliminated, since the Post Office Department is now responsible for this function.	34
22. The Dependents' Service should be an integral part of the hospital, with no more organizational stature than other professional services and without separate adjunctive services, such as a special laboratory or pharmacy. It should not be treated as an independent organization.	339
23. The Pharmacy Service should be included with the professional services rather than the administrative divisions, as indicated in the Manual.	317
24. The Laboratory Officer should be responsible for epidemiology functions.	309

25. The Rehabilitation Service should be discontinued in its present form as a separate professional service for peacetime operations. The functions currently assigned to it should be distributed to other appropriate units within the hospital in accordance with recommendations number 19, 20, 26, and 27. 351
26. Physical Therapy should be reassigned as an added activity in the orthopedic service under the Chief of the Surgical Service. 347
27. In those general hospitals which have a Red Cross arts and skills shop an occupational therapy technician should be physically located in the arts and skills shop to service the few patients requiring prescribed therapeutic treatment, and the hospital-operated occupational therapy shops should be discontinued. 348
28. Naval hospitals should immediately establish liaison with the Veterans Administration regional directors to clarify the responsibilities of each agency relative to the disposition of the remains of Veterans Administration patients. 164

#### PERSONNEL ADMINISTRATION (MILITARY)

1. The basis on which Hospital Corps officers are selected for permanent rank should be studied for possible improvement. 42
2. Hospital Corps officers should be thoroughly trained in one specialty. Assignments should be made on the basis of training, and transfers to new specialties should be limited to the most capable officers. 43
3. Hospital Corps officers selected for assignment in the Finance Division should receive more training in accounting and related fiscal subjects. 178
4. The assignment of Hospital Corps officers as Maintenance Officers should be avoided. A Civil Engineer Corps officer should serve in this capacity. 195



	Page
5. The tour of duty for Hospital Corps officers and enlisted technicians should be extended to reduce turnover and alleviate the <sup>serious</sup> services training problem with which many hospitals are now confronted.	41
6. The best enlisted corpsmen should be offered opportunity and training for more rapid promotion to officer rank.	41
7. Administrative and supervisory training for enlisted personnel in the various administrative divisions, as a basis for future duty as Hospital Corps officers, should be restricted to chief pharmacist's mates and pharmacist's mates, first class.	249
8. Corpsmen should be assigned only to administrative duties which have a relationship to future duty with the fleet. They should not be employed full-time in such activities as the garage, fire department, gate guard force, linen room, commissary, or on ward galley details.	221
9. Hospital Corps personnel rather than civilians should be assigned to those clerical duties, which must be covered the full seven-day week, such as the Admission Unit, and where training is useful for fleet duty.	130
10. Personnel assigned to the Hospital Corps Detail Desk should be thoroughly trained in military personnel administration.	41
11. A considerable number of nurses and corpsmen should be transferred from administrative duties to the wards to relieve the nursing shortage.	323
12. In some hospitals the distribution of nurses between the dependents' service and the regular hospital wards is out of proportion (Exhibit 22). Nursing care which should be allocated to service personnel should not be diverted to dependents.	324
13. A supervisory training course should be compulsory for all nurses, since nurses are responsible not only for supervising but also for training corpsmen assigned to their wards.	320

	Page
14. Ward nurses should be indoctrinated in local ward procedures at the time of their assignment; follow-up training should be given periodically.	319
15. Nurses in central surgical supply and the linen room should be replaced by chief pharmacist's mates.	209
16. Civilian physical therapists and occupational therapists should be employed in lieu of nurses for these specialties to relieve the current nurse shortage.	349
17. Where there is a surplus of chief pharmacist's mates, they should be detailed to ward duty either in lieu of nurses, as senior ward corpsmen under the supervision of the ward nurse, or as supervisor of cleaning details for several wards, depending on the local situation.	322
18. Ward corpsmen should be given more intensive practical training in nursing on the wards.	320
19. Job descriptions should be prepared for all military occupations in naval hospitals. Special attention should be given to the duties of ward corpsmen to determine ratings commensurate with the difficulty and responsibility of the duties performed.	323
20. Hours of work for ward corpsmen should be reduced to a basic eight-hour day, or approximately a 50-hour week, as compared with the present work-week of 60 hours or more.	320
21. Special qualification ratings should be established for EENT Technicians.	297
22. Special patient watches should be a full-time assignment for corpsmen rather than additional duty.	42
23. Nurses and ward corpsmen should be trained in the use of fire-fighting appliances.	265



	Page
24. Waves and corpsmen in the Dependents' Service should be relieved of many tasks which can be performed by civilian maids.	340
25. The Bureau should make every effort to obtain Marines for guarding prisoners. The policy pertaining to the availability of Marines for guarding prisoners and for gate watches should be clarified.	263
26. The system of granting liberty in hospitals should be the same for all enlisted personnel, regardless of rate.	41

#### PERSONNEL ADMINISTRATION (CIVILIAN)

1. The civilian personnel program outlined in paragraph 1512.2 of the Manual of the Medical Department should be activated in all hospitals.	45
2. A personnel officer (civilian) who is professionally qualified in all phases of personnel administration should be placed in charge of the civilian personnel section. He shall be responsible to the personnel officer.	49
3. A complete job analysis of all unclassified and many classified hospital occupations should be made immediately by the Bureau. Special emphasis should be placed on commissary and maintenance occupations.	49
4. A comprehensive wage pattern for unclassified hospital occupations should be established on the basis of the job analysis. The rates of pay should be adjusted to conform to local area wage practices.	49
5. The job descriptions should be used for the other phases of personnel administration, such as providing adequate hiring specifications and clear statements of the type of work expected of the incumbent, and indicating lines of promotion.	51
6. Workers should not perform duties of lesser skills than job description for the title of their position specifies. Excess employees in supervisory positions should be removed, and improper grading of employees should be	

- corrected. Misassignments should be corrected at a time when the impact will be felt the least, i.e., during reduction-in-force, at times of wage increases, by the replacement of employees voluntarily separated with properly rated employees, or, when necessary, by demotions. Such action requires the closest liaison between the hospitals and the Bureau. 52
7. An effective employment and placement program should be initiated by the civilian personnel officer. Greater emphasis should be placed on in-service placement and promotions. 53
8. A supervisory training program for foremen and heads of units should be initiated and conducted by the Civilian Personnel Officer. 53
9. A "replacement training" program should be planned and conducted continuously for all civilian and military employees performing specialized clerical tasks, to prevent interruptions in work flow and output due to absence or turnover. 121
10. Employee relations should be centrally controlled to provide consistency in such matters as efficiency ratings, discipline, grievance, and the interpretation of personnel policies. Grievance procedures should be established and explained to all employees. 55
11. Accumulated annual leave for civilian employees should be reduced to a minimum of 30 days. Once reduced, leave should not be allowed to accumulate beyond 30 days. 57
12. Personnel records should be standardized and centralized. The basic files should consist of a complete documentary record pertaining to the employee, a visible summary card file, and a file of position descriptions and job definitions. 56
13. Positions requiring continuity for effective performance such as section heads in the personnel and finance divisions, should be filled by civilians. 179



	Page
14. A new position of civilian maintenance supervisor should be established in lieu of the present foremen mechanic in the maintenance division to improve the quality of supervision. Minimum requirements for the position should include two years' college education in mechanical or civil engineering, or equivalent experience, plus appropriate supervisory experience.	197
15. Job definitions for the four basic laundry occupations, i.e., Chief Laundryman, First Laundryman, Laundryman, and Laundry Operator, should be clarified. A limiting grade structure should be established and followed.	210
16. Hospitals should distinguish between "Machinist (automotive)" and "Automotive Mechanic" and between "Automotive Mechanic" and "Helper, Automotive Mechanic" in accordance with the definitions listed in the Navy Department Guide Line Job Description.	220
17. Clear statements of duties are of particular importance in the Shops and Grounds Section to avoid misunderstanding as to the nature of the duties to be performed and to provide a sound basis for removal and replacement actions during reduction-in-force.	230
18. A new rating should be established for janitors.	244
19. All full-time fire-fighters should be civilian employees.	266
20. The 48-hour week for fire-fighters should be discontinued. Shift schedules should be arranged to provide for three 24-hour days in one week and two 24-hour days the following week.	266
21. Rigid employment and performance standards should be established for civilian guards. The quality of performance of civilian guards can be improved by stricter supervision and the employment of better personnel practices.	264
22. An eight-hour day, five-day week should be established at all hospitals employing 50 or more commissary workers.	248

	Page
23. One civilian steward should be employed at each hospital to provide the necessary continuity, relieve the commissary officer of much of the overload and act in his absence. Only large hospitals would require a chief cook in addition to a steward.	246
24. Flexibility in the assignments of commissary workers should be stressed in order to make full utilization of the available manpower.	248
25. The use of female workers as mess attendants should be controlled by complete statements of physical requirements in the position description. Many of the mess attendant jobs, particularly in the larger hospitals, can be adequately performed by women.	248
26. Civilian maids should perform all ward galley work for dependents' services. No corpsmen should be used full-time for ward galley details.	253
27. A consistent policy should be established for the use of workers in the maintenance of staff officers' quarters (excluding nurses' quarters). The title of "Maid" should be avoided for personnel employed for this purpose.	271
28. A civilian receptionist clerk should be employed in EENT clinics having a workload of over 500 visits per month.	279
29. A civilian stenographer whose duties would include receptionist work should be employed for X-ray Services having a workload of 600 or more X-ray examinations per month. One female civilian X-ray technician should also be employed to assist in training, provide continuity, and to service dependents.	301
30. Approximately one-third of the laboratory service staff should be civilian laboratory technicians. Complete employment specifications and pay rates should be determined before the positions are established.	310
31. Civilians should be employed for cleaning and galley work in extremely active wards where patients are not available for details and in the Dependents' Service.	340



METHODS AND PROCEDURES

1. A joint study should be initiated by the Bureau of Naval Personnel and the Bureau of Medicine and Surgery to explore the possibilities of utilizing the Navy Personnel Accounting System for the tabulation of personnel data presently being furnished the Bureau of Medicine and Surgery in a series of several reports. The following forms could be eliminated upon the adoption of this system:
  - a. Receipt, Transfer, and Status Card, NAVMED-HC-3.
  - b. Roster Report of the Hospital Corps, NAVMED-HC-4.
  - c. Admission or Discharge of Officer, NAVMED-HF-1.
  - d. Roster Report of the Medical Corps, NAVMED-953.
  - e. Weekly Report of Enlisted Hospital Corps, USN/USNR on Board for Duty and Instruction (letter report).

159
  
2. Until such time as a definite decision is made regarding the revision of the personnel reporting procedures, however, naval hospitals should employ a uniform method of preparing and processing all reports currently in use. Standardized procedures for each desk in the personnel division are recommended in Appendix I.
 

161
  
3. The proposed standard procedures for activities in the Personnel Division (Appendix I) and for ward administration (Appendix I) should be used as the basis for the preparation of internal procedures manuals or job instruction guides as aids in job indoctrination or replacement training.
 

157
  
4. The proposed Admission Card (Exhibit 17) should be adopted as a standard form, and the printing of a variety of local admission cards should be eliminated. In this connection, the Muster Card, NAVPERS-617, should also be eliminated. Distribution of the Admission Card should be as outlined in Exhibit 17A.
 

130
  
5. With the adoption of the proposed standard Admission Card, various memoranda, local file cards, and miscellaneous logs used presently in the admission procedure should be eliminated.
 

130

	Page
6. Each hospital should review all local forms to determine their essentiality, eliminate obsolete forms, consolidate necessary forms where possible, and revise the local numbering system for control purposes.	121
7. A forms design and control system should be established under office services for more economic utilization of local forms.	275
8. The Bureau of Medicine and Surgery and the Veterans Administration should clarify their respective responsibilities in connection with serious and critical list patients, and the disposition of deceased Veterans Administration patients.	164
9. The practice of preparing Veterans Administration reports and forms for the convenience of the Veterans Administration regional offices should be discontinued. Special file cards prepared on individual patients who are placed on the serious and critical list are not necessary and should be eliminated.	164
10. Interim reports and photostats of clinical records on actively-hospitalized Veterans Administration patients should be discontinued since complete clinical histories are eventually furnished the Veterans Administration.	146
11. Naval hospitals should recognize the VAP-10, Application for Hospitalization or Domiciliary Care, as official authority for the admission of a Veterans Administration patient and as a basis for reimbursement from the Veterans Administration.	146
12. The IBM accounting system should be fully utilized to furnish summary morbidity data based on the receipt of current statistics on individual patients, thus eliminating periodic morbidity reports from naval hospitals.	141
13. In order to expedite the preparation of the Weekly Report of Patients, NAVMED-I, a daily worksheet should be designed to conform with the classification and columns as shown on the weekly report, with one page for seven days' admissions and discharges, and with space provided at the bottom of the page for the weekly summary on Navy and Marine patients.	143



14. The letter report, Weekly Report of Assignment and Housing of Hospital Corps Personnel, should be eliminated. The quarterly Hospital Bed Capacity Report, NAVMED-103, furnishes sufficient housing information, and the assignment of Hospital Corps personnel is covered in the Daily Personnel Diary, NAVPERS-501. 160
15. All hospitals should be advised immediately to order the new Standard Transfer Order, NAVPERS-563/NAVS&A Form 36, and discontinue the use of all district transfer order forms. The Standard Transfer Order will also eliminate the need of four supplementary Medical Department forms NMSH-3, 4, 5, and 7. 152
16. The Bureau of Supplies and Accounts and the Bureau of Naval Personnel should be contacted regarding the necessity for their respective forms NAVS&A-510 and NAVPERS-601, (page 9Y) in view of their duplication with the Standard Transfer Order which is a joint NAVPERS-NAVS&A form. 153
17. The organizational nomenclature used on the Roster Report of the Hospital Corps, NAVMED-HC-4, should be standardized. 166
18. Personnel who go on leave should be indicated on Ward Report, NAVMED-HF-9, as "inter-ward transfers", between their respective wards or other duty assignment and the leave desk. Upon their return from leave they should be transferred back from the leave desk to the ward or other assignment. 154
19. The proposed Health/Service Record Receipt Card (Exhibit 24) should be adopted as a standard NAVMED form, for controlling the location of Health and Service Records within the hospital. 144
20. The Abstract of Antilustic Treatment, NAVMED-H-7, should be revised to include the branch of service of the patient; other personnel, such as dependents, civilian workers, etc.; and race. The form should be prepared in duplicate; the original forwarded to the Bureau, and the copy filed in the man's Health Record. 144

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21. The Annual Syphilis Report, NAVMED-A, should be eliminated since the information required has already been submitted on NAVMED-H-7. 144
22. Bureau approval of or action on medical surveys submitted by the hospitals should be expedited. At the present there is a time lag of three to six weeks. 145
23. Metal seals, numbered serially, should be used in lieu of the present system of checking personal effects of patients against the Hospital Ticket. 131
24. The following Bag Room forms should be revised as indicated in the text:
- a. Hospital Ticket, NAVMED-G.
  - b. Hospital Ticket - Women, NAVMED-416.
  - c. Personal Effects Tag, NAVMED-HF-22. 171
25. All unclaimed baggage should be prepared immediately for shipment to official baggage disposal centers. 171
26. All official incoming correspondence should be opened, time-stamped, screened and routed for action by the central files unit. 175
27. The Expense Analysis Register should be revised (as proposed in Exhibit 15) to include reporting on a purely organizational basis, complete workload information for each unit, and the number of civil employees and military personnel in each unit. 80
28. All hospital administration operations should be based on the standard functional organization. Fiscal accounts, in particular, should be set up to follow the organizational pattern of the hospital. 177
29. Pay and allowances data for military staff for the "Expense Analysis Register" should be maintained on a monthly rather than a daily basis. 181
30. The new Kardex medical stores record system should be set up and fully utilized at all hospitals, and the maintenance of Form "W's" should be discontinued. 179



	Page
31. Stores records are an integral part of the storeroom operation, and should be located in the immediate storeroom area rather than in the main finance office.	179
32. Separate receiving records should not be prepared on requisitions which are received in full. Numerous logs and records maintained by receiving clerks are not necessary and should be discontinued.	180
33. Excessive stocks of open purchase drugs should be reduced. Open purchases should be curtailed to a minimum consistent with effective hospital performance. Practical usage rates and realistic order points should be established for all drugs, and utilized in the ordering of supplies.	181
34. A simplified requisition form should be devised to replace the Form "R" for internal use in submitting requisitions for housekeeping supplies, etc.	182
35. Operating personnel should assist the finance division in conducting inventories of their respective divisions or services.	180
36. "Decals" should be used to mark small metal equipment.	180
37. The civilian payroll procedure should be simplified and standardized. Maximum use is not being made of bookkeeping machines and other labor-saving devices.	182
38. The maintenance officer should approve all routine requests for repairs. Only those orders which involve a considerable amount of materials and money or which appear unnecessary should be forwarded to the executive officer for review and decision.	233
39. The expenditure of materials on a maintenance job should be noted on the reverse side of the Work Repair Request, NAVMED-63. This information should be used in determining the needs and controlling the use of materials by the individual shops.	233

40. The Laundry List, NAVMED-HF-21 should be revised and used for both laundry lists and periodic inventories. Local laundry lists should be eliminated. 212
41. Hospitals should maintain daily records, and report monthly laundry production in terms of total pieces of laundry, and in the same terminology as on the revised Laundry List, NAVMED-HF-21. 212
42. The number of automotive vehicles in operation should be reduced to the minimum necessary to provide adequate service. 221
43. The clerical procedure in the transportation section should be simplified and standardized around two basic forms, the Vehicle Trip Report, NAVEXOS-371, and the Daily Log Sheet, NAVEXOS-280. Duplicating logs should be eliminated. 221
44. Forms and records procedures of the commissary division should be revised and standardized. The Bureau, in conjunction with the Commissary Department of the Hospital Corps School, Bethesda, should undertake the task of standardization. 250
45. The Ration Record, NAVMED-HF-36, should be reviewed for possible revision to simplify and include breakdowns or classifications by group, instead of classifications by individual types. 249
46. Dishwashing should be performed on the wards, but the cleaning of food carts should be the responsibility of the main galley except where full-time galley workers are employed in the ward. 253
47. The method of charging maid service on the Expense Analysis Register accounts should be clarified. Dining room duties which some maids may perform as an incidental portion of their maid duties for staff quarters should be charged against the account "E-303 Staff Quarters." The commissary division, account "E-310 Commissary", should be charged only for cooks, mess attendants, etc.; never for maid service. 255



	Page
48. Procedures should be developed locally to insure the collection of charges for hospitalization from dependents and other supernumerary patients by the agent cashier before they leave the hospital.	189
49. A more rigid loan policy should be established in the medical library to reduce the number of lost books. Personnel who fail to return books should pay for replacements.	273
50. The Bureau should take prompt action to fill commanding officers' requests for authorized books for the medical library.	273
51. Manual telephone systems in all hospitals should be converted to automatic systems.	279
52. All hospitals should utilize the standard NAVMED-HF-57, Special Examination and Treatment Request, and eliminate the use of local forms in connection with special examination and treatment requests.	121
53. The method of reporting EENT examinations and treatments should be clarified. The distinction between examinations and treatments should be discontinued, and reports prepared in terms of "visits".	297
54. The Bureau should issue instructions to clarify what EENT and Urological operations should be reported on NAVMED-P.	284
55. The Bureau should issue instructions regarding the use of standard nomenclature in X-ray production reports, and a method of reporting production to provide uniform cost allocation. Examinations and treatments need not be listed separately.	302
56. The method of counting laboratory examinations and the system of maintaining laboratory logs should be standardized.	310
57. Requests for routine laboratory examinations on incoming patients should be made by the admission unit, and the results of the examination sent direct to the appropriate ward.	310

58. Orders for drugs and other pharmaceutical supplies should be delivered to the pharmacy only at a specific period to be designated by the hospital. 317
59. The maintenance of logs and written records for drugs received and issued, with the exception of narcotics, poisons, and alcohol should be eliminated. 317
60. Specific dental consultation and examination periods should be established. 291
61. The maintenance of duplicate records on dental supplies and equipment in the dental service and the finance division should be discontinued. 291
62. The procedure recommended in the text for insuring complete dental information in the Dental Record should be adopted. 290
63. The Semi-Annual Dental Report, NAVMED-461, should be discontinued, and all necessary personnel data should be furnished on the Semi-Annual Dental Officer Personnel Report, NAVMED-785. If the two reports are consolidated, the title of the new report should be changed to "Dental Personnel Report." 293
64. Consideration should be given to the elimination of the Monthly Prosthodontia Report, NAVMED-610. 292
65. The five classifications for patient rehabilitation should be reduced to two. Class I should include both those patients with no physical activity limitations and ambulant patients with limitations as specified by the doctor. Class II should include those patients confined to bed or ward. 350
66. The rehabilitation clerk in the personnel division should interview each patient in Class I, who is sent to him by the ward doctor, assign the patient to an appropriate detail, and prepare a rehabilitation card. The card is signed daily by the patient's supervisor and should be used as a basis for granting liberty. 350



	Page
67. The established policy relative to types of dependents cases to be admitted for in-patient care should be uniformly interpreted and applied.	341
68. An effective appointment system should be established and maintained for out-patients to avoid congestion and eliminate long waiting periods by patients.	341

#### WORK MEASUREMENT AND STAFFING REQUIREMENTS

1. Work measurement should be utilized by naval hospitals in determining, justifying, and controlling their staffing requirements. The basic work load indicator for hospitals should be patient load.	62
2. Hospitals of approximately the same patient load should have the same size staff in the organizational units, where the physical layout is of minor importance. These units include personnel, finance, disbursing, laundry, transportation, and all professional services.	63
3. Staff requirements for those organizational units where the physical layout is significant will vary from hospital to hospital, but can readily be determined for each hospital on an individual basis. The variation with patient load beyond the point where physical layout is dominant, however, should be the same for all hospitals. These units include the commissary division and such activities in the maintenance division as shops and grounds, fire department, and guard force.	63
4. Staff requirements for activities such as the power plant and telephone section should be the same for all hospitals where the equipment is similar.	63
5. The following proposed standard staff requirements, based on work load expectancy, should be adopted to provide uniform staffs for naval hospitals:	

Table 3	Standard Naval Hospital	82
16	Personnel Division	127
18	Finance Division	186
20	Disbursing Office	192
22	Laundry Operation	217
24	Transportation Section	225
31	Shops and Grounds Section	242
36	Commissary Division	258
38	Security and MAA Division	269
40	Main Operating Room	286
43	Dental Service	295
45	EENT Service	299
47	X-Ray Service	305
50	Laboratory Service	313
53	Nurses	327
55	Ward Corpsmen	329
58	Dependents Service	345

The standards established are tentative and should not be considered as fixed. Based on present policies and procedures, most of the standards proposed herein are accurate to within 10 percent.

6. The complement of the civilian personnel section (excluding the payroll function) should be established at one percent of the total civilian complement. The complement of the typical heating plant should be based on two workers per shift, or a total of 11 or 12 for all contingencies. The complement of the typical telephone section with automatic equipment should be six, which includes one operator each for the second and third shifts. Complements for janitors should be justified on an individual hospital basis. 68
7. The present distribution of corpsmen - 34 percent in the administrative divisions, 39 percent in the wards, and 27 percent in the other clinical services, such as laboratory, X-ray, etc. - should be changed to 20 percent, 50 percent, and 30 percent respectively (Exhibits 12 and 22A). 321
8. The ratio of patients to nurses for service patients (as distinguished from dependents) should be 10 to 1, instead of the current on-board ratio of 16 to 1; and the ratio of patients to ward corpsmen 6 to 1, instead of 7.5 to 1 (Exhibit 21). 324



## 9. Action should be taken to reduce personnel overhead by:

- a. Physical consolidation of organizational units, particularly within the commissary division.
- b. Consolidation of such overhead functions as fire department, power plant, telephone service, or even, in the very small hospitals, laundry and maintenance, with those at other naval activities in the area.
- c. Close control of complement through comparison with staffing standards.
- d. Consolidation of hospitals where the military situation permits.
- e. Proper balance of patient loads between two or more hospitals.

Personnel overhead and, therefore, cost per patient day increase as the patient load drops. The average patient load of naval hospitals at the present time is very near the point where cost per patient day accelerates rapidly.

73

10. Work measurement standards should be used as a guide in determining if the amount of work being performed in a particular organizational unit is normal for the patient load.

69

11. Civilian and military allowances within a hospital should be closely coordinated and controlled by the same organizational unit. Responsibility for establishing both civilian and enlisted allowances for hospitals should be centralized in one division in the Bureau of Medicine and Surgery.

78

12. Hospitals should report work load on a modified form of the Recapitulation of Ledger Accounts, NAVMED-569. Data obtained from individual hospitals should be made available to all hospitals for administrative use through the circulation of summary sheets by the Bureau.

78

PHYSICAL LAYOUT

1. Hospital facilities and organizational units should be consolidated internally wherever possible to allow for minimum staffing and to facilitate operations.

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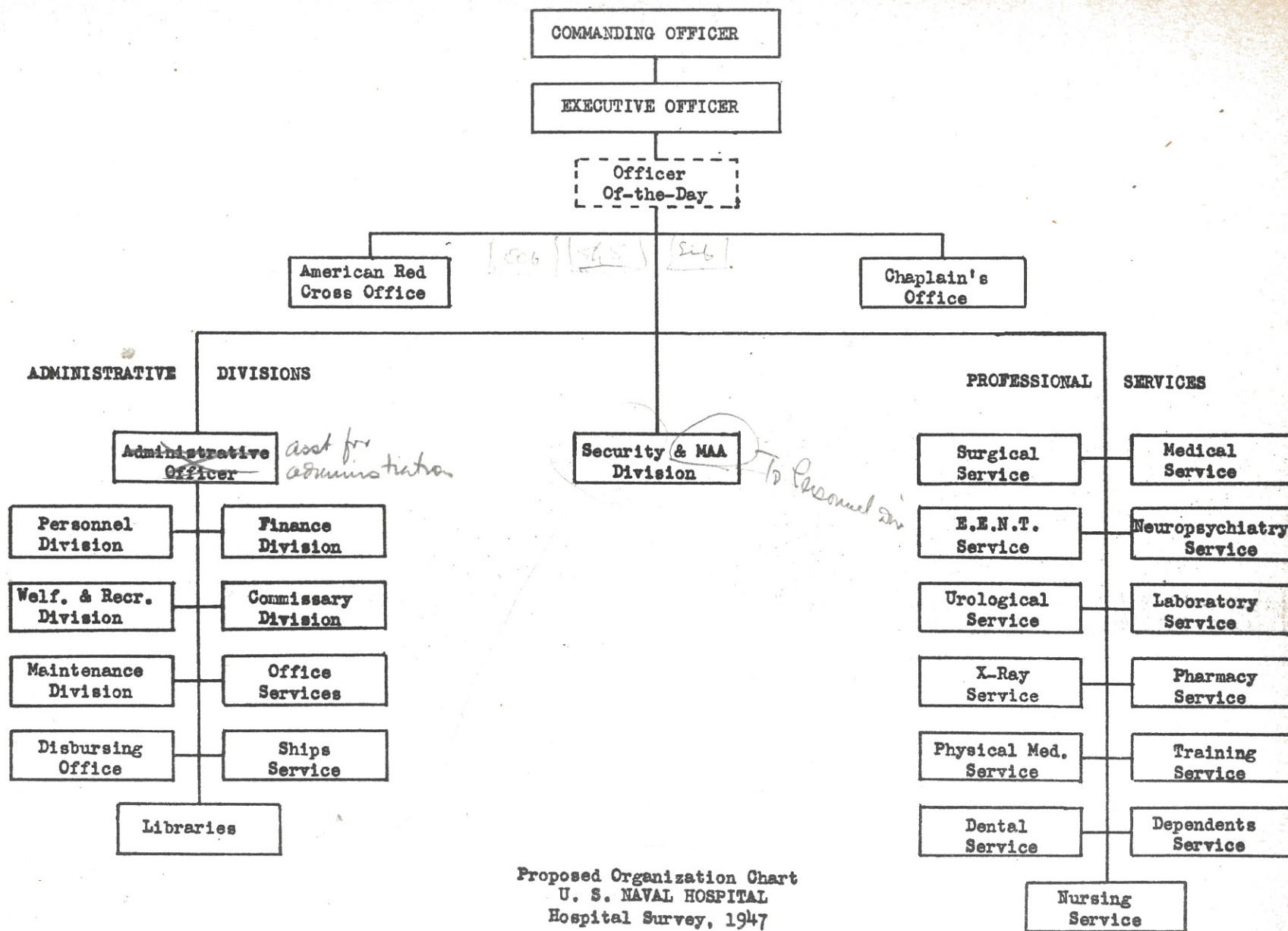
2. Special emphasis relative to the selection of the types of design for construction of naval hospitals in the future should be placed on minimum staff required for efficient operations and possible expansion in the event of an emergency. In this connection, the "hub and spoke" building design should be considered. The main hospital units would be located in a large hub, and the wards would comprise the spokes. 75
3. When the military situation permits, excess obsolete buildings should be demolished; particularly when such action will result in a savings in maintenance personnel, elimination of excess heating costs, and removal of serious fire hazards. 74
4. Office services should be consolidated and located near the office of the administrative officer for complete utilization of services and better administrative control of office service personnel. 275
5. All activities of the personnel division should be located in close proximity. It is particularly important that the information desk and directory service be next to each other, and that the admission unit and bag room be in the same immediate vicinity. 170
6. A private room or enclosed space should be provided for interviews with next of kin of deceased personnel in hospitals having a relatively high number of deaths. 163
7. The central linen room should be physically located immediately adjacent to or as part of the laundry. 209
8. The heating plant should be tied in with power plants in adjoining Navy establishments, where the cost of a tie-in steam line is justified by personnel savings or is of special value for emergency service. 228
9. Commissary facilities, wherever practicable, should be consolidated with the general aim of providing all commissary facilities in one location. The extent of alterations should be determined by the amount of payroll savings expected. 251



	Page
10. The medical library and the recreational (crew's) library should be located adjacent to each other.	274
11. Rest room facilities should be provided immediately adjacent to the telephone office.	279
12. Adjunctive clinical services, particularly laboratory, pharmacy, X-ray, should be located centrally and close together and be easily accessible to the other professional services, in order to minimize the number of time-consuming trips now required of ward corpsmen.	73
13. Branch pharmacies should be consolidated with the main pharmacy where permitted by the physical layout of the hospital.	317
14. The physical layout of pharmacies should be improved for more effective utilization of space. Window-type dispensing counters should be installed to prevent entrance of unauthorized personnel.	318
15. Special pharmacy, laboratory, and other services for the dependents' service should be avoided in the interest of economy.	339

## II ORGANIZATION





## ORGANIZATION OF NAVAL HOSPITALS

The basic organization prescribed for naval hospitals by the Manual of the Medical Department is generally adhered to at all of the hospitals studied. Observations and discussions at the hospitals have disclosed that this basic outline is fundamentally sound. The chart, as with any organization chart, requires a few revisions to make it current, but the basic functional breakdown is practical and effective. Organization difficulties in the hospitals have been caused chiefly by failure to follow the chart or differences in interpretation of the duties and responsibilities of key positions rather than by the chart itself. These differences in interpretation are inevitable, since the Manual fails to include complete functional statements. Further, the key position of assistant to the executive officer for administration is not clearly defined. As a result, there is no clear conception concerning the function of this position. Too often, organizations have been modified to fit the capabilities of individual officers assigned to the hospital staff, rather than the officers trained to perform the job prescribed by the organization.

In general, however, the assignment of major functions has been so effective as to obviate the necessity for major organizational changes. Standardization is not only possible, but an accomplished fact. It is most important, therefore, that the entire philosophy of hospital administrative operations be based on this functional organization, particularly for fiscal control.

The following discussion is concerned primarily with recommendations to bring the organization up to date, to correct apparently contradictory statements of functions in the Manual of the Medical Department and to assign subordinate, but necessary, functions to appropriate divisions and services (Exhibit 1).

Overhead and Direct Operations: Most industrial organizations allocate costs to so-called productive and overhead departments which fit the production pattern. In hospitals, however, the "product" is a patient, and, for certain administrative operations, the normal concept of overhead and direct charges cannot be reflected logically in organizational units. For example, the preparation of food for patients is a direct charge, while the same service for staff personnel is an indirect charge. There are also many record-keeping operations which are common to both patients and staff.



Therefore, certain normal organizational patterns which are logical for industry or civilian hospitals are not the most efficient for naval hospitals. The general approach has been to consolidate by similarities in function, rather than by overhead or direct costs.

#### ORGANIZATIONAL CHANGES

The actual organization charts of Philadelphia and Portsmouth (Exhibits 2 and 3) illustrate how complicated the internal organizational structure of some hospitals has become and indicates the need for simplification within several major divisions. Proposed organizational changes in individual divisions and services are discussed in the sections of this report devoted to them. Organizational problems common to several organizational units are discussed below.

Assistant to the Executive Officer (Professional): The organization chart and paragraph 16A25 of the Manual of the Medical Department provide for the position of assistant to the executive officer (professional). This position does not exist at any of the hospitals. Responsible personnel at each hospital think that the position is impractical, unnecessary, and not justified economically. The executive officer performs all the duties of this position at four hospitals. At San Diego, the chief of the surgical service and the chief of the medical service perform some of the administrative functions, relieving the executive officer of part of the details.

There is no need for the position of assistant to the executive officer (professional) in naval hospitals. It serves merely as an additional layer of command and can easily become a bottleneck. The position, therefore, should be eliminated, and the chiefs of all professional services should report directly to the executive officer. The executive officer can handle this work load, provided he is relieved of the administrative duties discussed in the succeeding paragraph under "Assistant to the Executive Officer (Administrative)."

Assistant to the Executive Officer (Administrative): The key administrative position is the assistant to the executive officer (administrative).\* The relationship between this position and the executive officer not only affects the entire administrative operation of a hospital, but may offer a partial solution to the major problem of the assignment of Medical Corps

\*Hereafter this position will be referred to as Administrative Officer.

officers as administrators. The survey team devoted considerable time to the problem and discussed it with many Medical Corps and Hospital Corps officers.

Paragraph 1510 of the Manual of the Medical Department which outlines the duties of the administrative officer, states that he "...shall coordinate the work of the various administrative divisions of naval hospitals." According to the organization chart, he is the line supervisor as well as coordinator of these divisions, but this function of direct line supervision is not clearly defined in the Manual.

The duties and responsibilities assigned to or assumed by the administrative officer vary widely in the several hospitals. At two of the hospitals the authority of the administrative officer approaches line control; at two others he has practically no line authority, but is, in practice, more a personal aide to the commanding officer or executive officer; at the fifth he operates midway between these two extremes.

The administrative operations of the hospitals where the administrative officer has been delegated authority are well organized and running smoothly. At the other hospitals, the executive officer is overburdened with work, and the chiefs of both the professional services and the administrative divisions lose considerable time waiting to see him. Further, at the hospitals where the executive officer is involved in too many administrative details the opinion prevails that he is not devoting sufficient time to professional problems.

Commanding and executive officers generally recognize that responsibility for administrative operations should be placed in the position of the administrative officer. Many of them are frankly reluctant to delegate such authority however, because they feel that, in many instances, the senior Hospital Corps officers do not have the training or basic qualifications for such a complex and demanding position. Many Hospital Corps officers also agree that there are not sufficient officers fully qualified for this position.

The administrative officer position is professional in its field and has not generally been given proper recognition. Its stature should be increased, and rank given commensurate with the high degree of responsibility. The position demands a wide variety of knowledge and experience. Men should be trained for the position, rather than the position adjusted and readjusted to the man who is temporarily filling it. Great care should be exercised not only in training Hospital Corps officers for this position, but in selecting qualified officers for training. The primary purpose is to shift administrative duties ultimately from the executive officer to the administrative officer, so as to free the executive officer for closer attention to professional problems. The establishment of a permanent Medical



Service Corps, with the emphasis on obtaining men with proper qualifications, is obviously the first step toward a solution.

The necessity for an administrative officer in addition to an executive officer in small hospitals is questionable. It is probably true that in a civilian hospital both of these positions would not be necessary. If the executive officer is considered primarily a training position for commanding officer, the existence of both the executive officer and administrative officer billets at small hospitals can be justified. Otherwise there is not sufficient work for two positions.

Officer of the Day: The officer of the day, according to the organization chart in the Manual, has line authority over the master-at-arms force. Actually, no hospital follows this practice.

From 1630 to 0800 the next morning the officer of the day acts in the capacity of the commanding officer and is responsible for all hospital operations, including the master-at-arms function, during these hours. During regular work hours, however, the security and MAA division (currently listed as chief master-at-arms) should be responsible to the executive officer. The hospital organization chart should be modified to meet the actual situation.

Staff Advisor to the Commanding Officer: The survey team concentrated on administrative problems common to all naval hospitals and avoided purely local issues as much as possible. The commanding officer or executive officer at each hospital, however, requested considerable information on local conditions during the course of the more general study. At the conclusion of each study, therefore, the survey team reported generally on local conditions which came to their attention.

It was impossible not to observe the many local problems which existed at the various hospitals. For example, the method used at Philadelphia in the delivery of food from the commissary to the wards, and the scheduling of such delivery, is extremely complex. Over 100 people are involved in this operation. The system for collecting and distributing laundry is also cumbersome and unsatisfactory. Office procedures are particularly complicated because of the veteran out-patient service. The method of distributing supplies and correspondence between wards and departments needs a thorough alteration. At most of the hospitals much valuable space is ill-used or wasted. Careful advance planning and closer attention to the control and anticipated use of office space, in particular, is needed.

The internal layout of such activities as the laundry and maintenance shops can also be improved at some hospitals. Planning the use of space and buildings is a large and ever-changing problem and requires constant analysis. These are only a few of the problems which exist at naval hospitals at the present time.

Commanding officers recognize the importance of finding solutions to these problems, but have no one on their staff qualified to do the work. These types of problems, involving physical layout, methods and procedures, planning and scheduling, fall normally within the province of the industrial or management engineer. In addition, there are numerous pure engineering problems, such as water supply, efficiency of the power plant, and justification for major alterations in buildings.

A hospital such as Philadelphia is a large and complex establishment, employing a staff of 1000 and doing a business which can be compared to an industry grossing \$10,000,000 annually. Yet no one is given the responsibility for solving these specialized planning problems. The chiefs of the administrative divisions and professional services are directly concerned with these problems, but there is no one to whom they can turn for professional advice and assistance. In addition, many of the problems overlap two or more divisions, and would more normally be the responsibility of a higher echelon.

The Bureau can provide such services to the hospitals as standardizing and eliminating reports, instituting better methods of complement control, and providing training assistance. The Bureau cannot, however, investigate and make recommendations on all the significant problems which occur at every hospital. Each hospital, or groups of hospitals, should have a competent staff assistant to work on the many local problems which arise in all phases of operations. It is highly desirable that a management engineer position as staff advisor be established at large hospitals to devote full-time to hospital management problems within the local area. While this individual would be attached to the staff of one hospital for administrative purposes, he should also service other hospitals in the area. For example, the staff advisor attached to the San Diego hospital would also service the hospitals at Long Beach, Corona, and Oceanside.

Office Services: Miscellaneous office services, including telephone, communication, mimeograph, photostat, office supply, and messenger activities, are scattered throughout the hospital both organizationally and physically.

It is recommended that these services be consolidated in a single unit, called "Office



Services", which will be responsible to the administrative officer. To provide maximal service, most office services should be located near the office of the administrative officer.

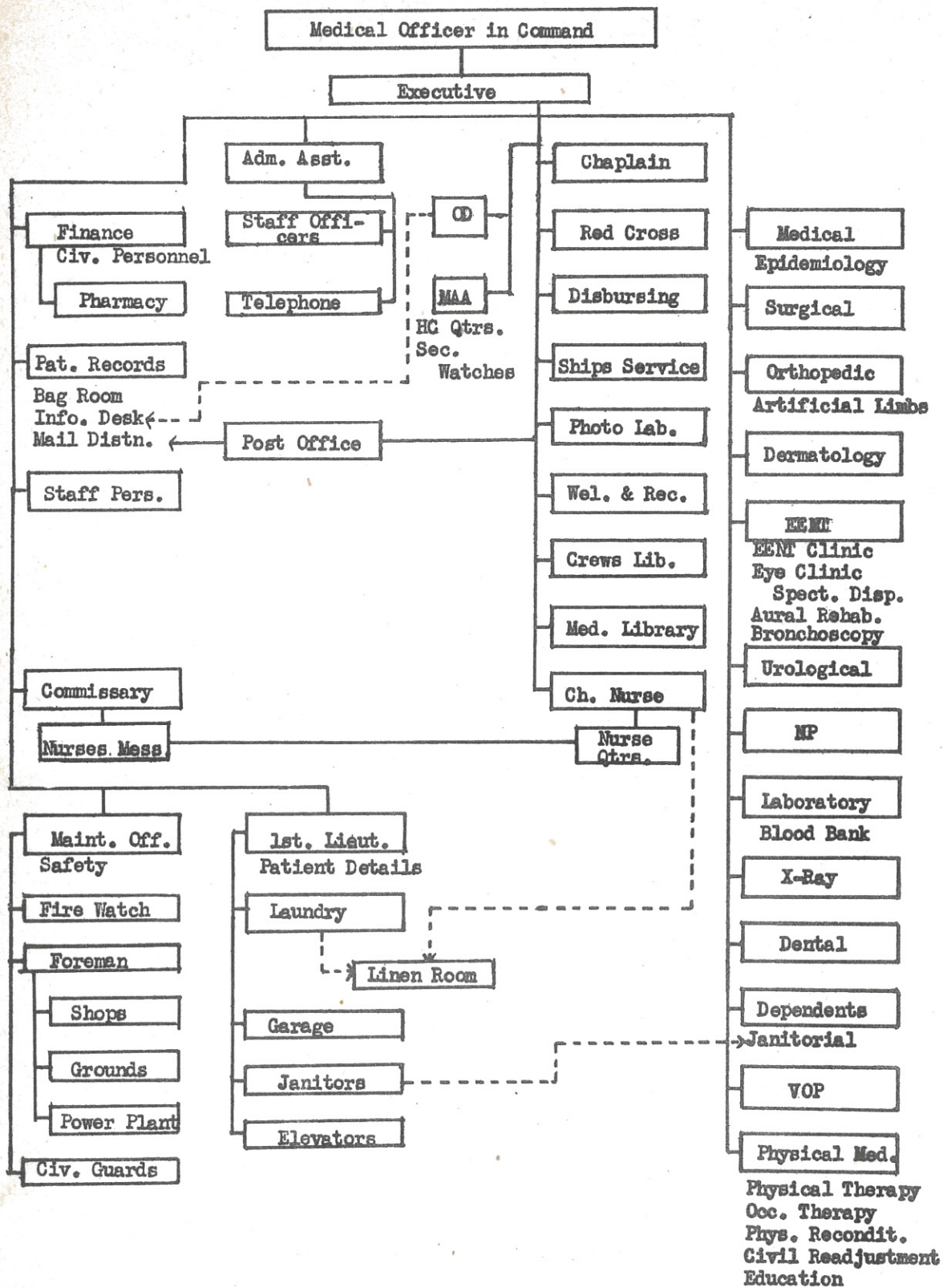
Postal Division: Since responsibility for postal operations at naval hospitals has reverted to the Post Office Department, and there is no longer any necessity for a Postal Division, the Postal Division should be deleted from the hospital organization chart.

#### RECOMMENDATIONS

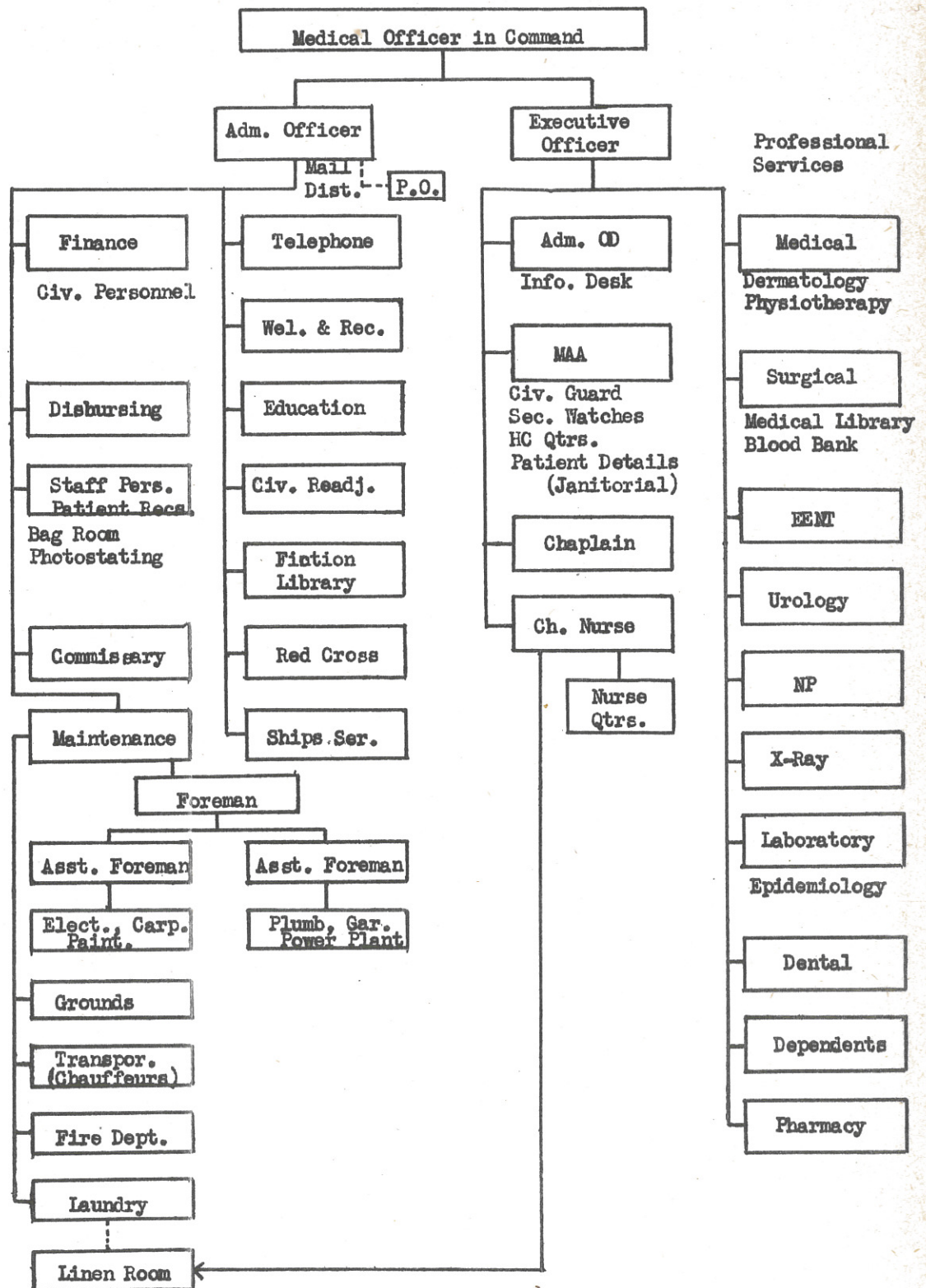
1. The proposed organization chart for naval hospitals (Exhibit 1) should replace the current organization chart in the Manual of the Medical Department.
2. The organization chart for naval hospitals (paragraph 16A5.2 of the Manual of the Medical Department) should be supplemented by functional statements clarifying the responsibilities of each division and service. Such small units as the bag room, admission desk, etc., should be assigned to appropriate major divisions.
3. All hospital administrative operations, particularly matters of fiscal control, should be based on the standard functional organization.
4. The position of assistant to the executive officer (professional) should be abolished. The chiefs of all professional services should report directly to the executive officer.
5. The functions of the assistant to the executive officer (administrative) should be clearly defined in the Manual, particularly to show line authority over as well as coordination of the administrative divisions. Men should be trained for the position, rather than the position adjusted to the officer who is temporarily filling it.
6. The title "assistant to the executive officer (administrative)" should be changed to "administrative officer." Rank commensurate with the high degree of responsibility should be given to the incumbent.
7. A management engineer position as staff advisor to the commanding officer should be established at the largest hospitals to devote full-time to hospital management problems both in the hospital to which he is attached and the other hospitals in the area.
8. The security and MAA division (listed on the current organization chart as chief master-at-arms) should report to the executive officer and not the officer of the day during regular working hours.

9. The officer of the day should be shown on the organization chart as being responsible for all hospital operations during the hours from 1630 to 0800 the next morning.
10. Miscellaneous office services, such as telephone, communication, mimeograph, photostat, office supply, and messenger activities, should be consolidated in a single unit, called "Office Services", which will be responsible to the administrative officer.
11. The Postal Division should be deleted from the hospital organization chart, since responsibility for postal operations at naval hospitals has reverted to the Post Office Department.













### III PERSONNEL ADMINISTRATION







## MILITARY PERSONNEL

Since weaknesses in administrative operations are often caused by faulty personnel administration, it is considered necessary to direct attention to certain military personnel problems existing at the hospitals.

Basic principles of personnel administration are the same, whether they are applied to military or civilian personnel. There is less flexibility in administering military personnel, but much can be achieved toward more effective utilization of the available manpower.

Assignment of Enlisted Personnel: A hospital has little or no choice in the selection of its enlisted personnel, but it does control the assignment of corpsmen to specific billets. The assignment process should consist of selecting positions for which the men will be most suited or, basically, matching the man's qualifications to the position requirements; yet this elemental principle is often disregarded. Corpsmen are often assigned with little consideration of their qualifications. Technicians are given more consideration as to the jobs they are to fill. While the stature of the Hospital Corps detail desk is increasing, it is still a long way from achieving optimum results. The more competent chief pharmacist's mates are now being assigned to this desk, but they are learning by trial and error without previous training for the job. Personnel performing the detail function should be trained and experienced in personnel administration. They must be able to make effective assignments of all corpsmen in order to attain maximum utilization of enlisted personnel.

Training and Turnover: Key hospital officials are greatly concerned over the lack of adequately trained personnel in many billets. They indicated that a shortage of trained personnel was expected after the war, but they believe that in too many instances personnel are indiscriminately transferred after the hospital has spent much time training men to perform effectively on a particular job. Hospital personnel emphasize that the tour of duty should be extended to reduce turnover and transfers should be kept to a minimum consistent with sound personnel administration, and, at the same time, as permissible within the confines of established Naval policy.

Liberty: One of the principal complaints of the average corpsman is the basis on which liberty is granted. In most instances liberty is granted according to rating, that is, hospital apprentices on port and starboard, and pharmacists' mates in order of rating on three-section, four-section or every night liberty. This system applies regardless of the duties



performed. Since most corpsmen are not rated, there are very often many more men on duty on the port, starboard, and evening watches than are required to perform the work. It is recommended that action be taken to insure that liberty is granted on a more equitable basis in order to improve corpsman morale. It is also important that the same system applies in all hospitals.

Special Watches: The assignment of corpsmen to special watches for patients in addition to their regular duties is a general practice. Many medical officers are opposed to this method because corpsmen are too tired to perform effectively, lose time on their regular duties, or are not sufficiently familiar with the duties required on special watches. In order to correct this situation, it is recommended that a pool of corpsmen be established for special watch duty on a full-time basis for a specific period. Any additional special watches should, of course, be filled in accordance with the present method.

Hours of Work: This problem is discussed under the section of the report pertaining to ward administration.

Hospital Corps Officers: Practically all key administrative positions of a supervisory nature are filled by Hospital Corps officers. It is therefore axiomatic that the efficiency of administrative operations depends to a large extent on the qualifications of these officers.

The positions filled by Hospital Corps officers are comparable in responsibility and difficulty to department heads in civilian industry. At a hospital such as San Diego, the commissary officer is responsible for an expenditure of about \$1,000,000 annually; in food, personnel services, and equipment. The personnel officer is responsible for records for over 15,000 patients and a staff of over 1,000. The maintenance officer is responsible for the maintenance of land and buildings valued in excess of \$1,000,000. The finance officer controls a budget of approximately \$3,000,000, while the administrative officer is responsible for all of these administrative operations. These positions demand experienced and trained people. Although many of the Hospital Corps officers who are assigned to these positions are doing an excellent job, there are also many others who do not possess the requisite qualifications. Both Medical Corps and Hospital Corps officers stated that they believed that this contrast in performance was caused by the fact that too frequently seniority, war service, personality, etc., are prime considerations for promotion or selection for permanent status, and that sufficient emphasis is not placed on certain minimum aptitudes and educational attainments.



In order to improve the present situation and obtain maximal performance, it is believed that the average officer should specialize in one type of duty, and should not be transferred, for example, from finance to commissary, then to maintenance, etc. Each of these jobs in present-day hospital operations is complex and specialized, and requires extensive training and experience. Many Hospital Corps officers feel that they are out of their field. The survey team discussed this problem with the supervisors of these officers, who indicated that the performance of many of them was not of the highest quality, primarily because they were either not adapted to or not interested in their particular assignment. More intensive training in one specialty for Hospital Corps officers already selected will contribute materially toward improving administrative operations. In the future, more emphasis should be placed on academic training and the evidence of minimum intelligence requirements in the selection and promotion of officers who are to assume important administrative positions in naval hospitals.

#### RECOMMENDATIONS

1. Assignments of corpsmen should be based on their individual qualifications.
2. Personnel assigned to the Hospital Corps detail desk should be thoroughly trained in military personnel administration.
3. The tour of duty for Hospital Corps officers, and enlisted men, should be extended.
4. The system of granting liberty should be the same for all enlisted personnel.
5. Special patient watches should be a full-time assignment rather than additional duty.
6. The basis on which Hospital Corps officers are selected for permanent rank should be studied for possible improvement.
7. Hospital Corps officers should be thoroughly trained in one specialty. Assignments should be made on the basis of training, and transfers to new specialties should be limited to the most capable officers.





## CIVILIAN PERSONNEL

The duties of the personnel officer is defined and in effect, a personnel management program is outlined in paragraph 1512 of the Manual of the Medical Department. At four of the hospitals such a program is non-existent and, at the fifth, ineffective. The total program consists primarily of a payroll activity (which is more properly a finance function) and usually one employee to interpret Navy Civilian Personnel Instructions. Personnel administration in naval hospitals has suffered because poorly qualified people have attempted to administer the program in the field, and because the Bureau has not supplied adequate direction and training in this phase of administration.

During the past ten years, many concepts of personnel administration have undergone radical changes. In many private industrial firms, these changes have become crystallized and accepted, in some cases subconsciously, by both management and workers. There is a lack of technical knowledge of the personnel field even among those administrators in responsible positions who accept and realize the necessity for positive personnel administration. This is not a fault of these administrators, but is caused by the fact that personnel administration has become a highly specialized field of its own.

The following is an excerpt from Hospital Organization and Management, by Malcolm T. MacEachern, well-known authority on hospital administration, which discusses some of the problems involved.

"Hospital administrators have had some awareness of the importance of good personnel relations for a considerable period of time. With the acute labor shortages incident to the war, there was thrust upon them the necessity of giving probably more attention to this phase of management than to any other hospital problem. Many administrators have for the first time employed personnel officers, because of the heavy labor turnover required that so much time be given to the interviewing, training, and orientation of workers. Having once discovered the advantages of centralized control of personnel relations, they will undoubtedly in this postwar period maintain a personnel department as an integral and necessary part of the organization.

"These leaders further asserted that each individual is unique and his individuality should be considered in job placement, and his development in job transfer



and promotion. To control this, specialists were needed - personnel managers. The new theories were not universally accepted at first by employers, but they began to change their views when it became evident that concerns operating under the new ideas attracted the better workers and showed higher production results.

"... The first thing that hospital managers should learn from industry is that many of the theories held 20 and 30 years ago relative to workers are not true today. One of these theories, namely that workers are primarily motivated by economic considerations, is erroneous....

"In a pamphlet, Training of Lay Personnel in Hospitals, the American Hospital Association states that trustees and administrators of large hospitals are agreed that with the exception of motive, theoretically there is no vital distinction between the running of a hospital and the running of any other service organization, that the same principles should govern the management of a hospital as have been found effective in business ....

"... no single item in the hospital budget equals the item of payroll costs, yet, as a general rule, we spend very little in making sure that this major expenditure is invested so that it will yield the maximum return, although this item not only represents large dollar investment, but failure to employ good personnel is failure to protect the hospital against loss and destruction.

"Large and successful industries have for a number of years realized the advantages to production in having well organized personnel departments. Similar or even greater benefits are possible in hospitals whose work is so vital on saving lives and whose activities involve many kinds of individual endeavor on the part of both professional and non-professional personnel. The modern hospital should have a personnel department with the same clear lines of organization and function that characterize the other services."

For practical purposes, personnel administration has been accepted and developed by management only when it has been demonstrated that lack of good personnel relations and personnel administration adversely affects the output of the individual worker. The following discussion emphasizes the excess cost due to the number of workers required and the sub-



standard quality of their work because of the lack of even a simple personnel program.

Wage and Salary Administration: Employees are concerned not only in the pay they receive, but in the method by which pay rates are determined. The principle of "equal pay for equal work" has dominated the labor relations picture for many years.

This principle is difficult to apply completely in Government service. Salaries for classified workers are determined by comparing the difficulties and responsibilities of the positions against standards established by the Civil Service Commission, which should be uniform throughout the country. Rates of pay for unclassified positions are determined by comparison against local area rates. Obviously, it is difficult to obtain equity between classified and unclassified positions. Moreover, positions such as guard, fire-fighter, and telephone operator are more akin to unclassified than to classified positions, the latter representing the so-called "white collar" employees.

The situation with respect to the establishment of wage rates of unclassified workers in naval hospitals is thoroughly confused. Established wage rates should reflect the going rates being paid for the occupation in the local labor market. However, a wartime agreement by the shipbuilding industry established standard rates throughout the country for certain trades, and this pattern is followed by the Navy for the same trades in the naval hospitals. Carpenters, plumbers, painters, etc., in the maintenance division of a hospital get almost the same rate in all hospitals in the United States. Rates for commissary workers, maids, laborers, and most of all, helper occupations, such as carpenter helper, electrician helper, and general helper, vary as much as 50 percent from area to area. This destroys any semblance of cross-equity between occupations. For example, journeymen at San Diego receive \$1.35 per hour, while helpers receive \$1.07 per hour. At Jacksonville, journeymen receive the same rate of pay, \$1.38, but helpers receive only \$0.87 per hour.

There is no consistency even among those occupations which vary in rate from area to area. Laundry workers receive exactly the same rate at San Diego as at Philadelphia, which leads to the false conclusion that labor market conditions in the two areas are roughly the same. However, commissary workers at San Diego average better than \$0.25 per hour more than commissary workers at Philadelphia. The situation becomes more complicated by the fact that in areas where navy shipbuilding is the dominant industry, such as in the Norfolk-Portsmouth area, rates established for navy shipyards, become the going rate for the area.



The chief difficulty lies in the fact that wage administration for naval hospitals has been carried out on a piecemeal basis, with an adjustment made here and there when sufficient pressure is brought to bear. There is no well-integrated program.

Wage inequities have a disastrous affect on morale, increasing turnover and creating a cause for grievances which in turn greatly reduce output. For example, in some of the hospitals studied, wage rates, particularly for commissary and laundry workers, compare very favorably with local area rates. Yet there is considerable dissatisfaction among the employees because of inequities within the hospital itself.

The fact that the wage rates have been improperly established is an even greater problem. Many employees are not performing the duties indicated by their title, and hence their pay rate needs adjustment. This situation is general and is second only to the present threat of job insecurity as the most important single factor in contributing to poor morale. Generally, employees are performing duties of lesser skill than their pay indicates, e.g., cooks are performing duties of mess attendants, first cooks the duties of cooks, first-laundrymen the duties of laundry operators, etc. In these instances, dissatisfaction is greatest among other employees performing these same duties but receiving less pay. In a few cases, employees are performing duties higher than their title indicates with equal dissatisfaction. The following example of a commissary division at one hospital is typical of the discrepancy between rates of pay and duties performed:

<u>Title</u>	<u>Rate</u>	<u>Present Complement</u>	<u>Should be</u>
Steward	1.18	1	0
Chief Cook	1.09	1	1
First Cook	.97	11	4
Cook	.86	17	7
Assistant Cook	.80	12	3
Pantryman	.86	6	3
Mess Attendant	.77	50	79
Meat Cutter	.97	1	1
Assistant Meat Cutter	.82	1	2
Baker	.97	2	1
Assistant Baker	.82	0	1
		<u>102</u>	<u>102</u>
Average Rate		\$0.829	\$0.796
Difference		\$0.033	or 4%

4% annually = \$7,000 saving at this one hospital.

These cases are not isolated, but represent fully one-half of all civilian unclassified employees.

The financial loss incurred by the Bureau is estimated to be in excess of \$100,000 per annum at the five hospitals, in terms of excess pay alone. The loss in production and time due to poor morale must be considerably greater.

Obviously, there is a lack of understanding as to the meaning of position titles and job definitions. Most of the division and section supervisors have never seen the definitions of the jobs under their cognizance. The job definitions are poor, but serve to give some indication of the duties and responsibilities of the positions.

The classification structure for classified workers is much better, although by no means ideal. Most of the value of the classification system is lost because there is no well-qualified individual in the hospital who can explain the system to the employees and supervisors. No one is sufficiently equipped professionally to assist classified workers in the preparation of position descriptions to insure appropriate classification.

A personnel officer who thoroughly understands the principles and practices of job analysis, and wage and salary administration is the primary need.

A thorough understanding of the nature of the work performed is another prime requisite in the formulation of a sound wage policy. Such understanding can be achieved only through complete and accurate position descriptions.

In practice, and for the immediate future at least, it appears that the main function of the Office of Industrial Relations (OIR), Executive Office of the Secretary, insofar as wage administration is concerned, will be to conduct area wage surveys. However, the description and evaluation of jobs to fit the local area wage pattern must necessarily be a Bureau function. In any case, the Bureau of Medicine and Surgery is very likely to receive secondary consideration from OIR in the matter of wage administration because of the relatively small number of positions under BuMed control.

It is believed that OIR will delegate authority to BuMed for wage administration consistent with the demonstrated ability of the Bureau to do the job. The Bureau cannot afford to wait for OIR to do its job.

One of the basic tools of personnel administration is the position description. It is recommended that the Bureau immediately undertake a complete job analysis survey of all unclassified civilian occupations at naval hospitals, plus those classified positions (such as guards, fire-fighters, telephone operators, etc.) which lend themselves to standardization. These jobs could then be properly evaluated and included with the local area wage surveys con-



ducted by OIR. It is most important that the job analysis study be done immediately to be most effective since OIR is conducting a wage survey now.

Since the organization patterns of the hospitals are similar, the basic unclassified jobs are the same. The similarity of jobs eases the problem of conducting a job analysis survey, and makes the results of the survey applicable to all hospitals.

Following is a list of the jobs which should be covered by a Bureau-conducted job analysis survey:

Finance

Storekeeper

Commissary

Steward  
Chief Cook  
Assistant Cook  
Mess Attendant  
Baker  
Assistant Baker  
Meat Cutter  
Assistant Meat Cutter  
Pantryman

Maintenance - Shops

Foreman (Maintenance Supervisor)  
Assistant Foreman  
Carpenter  
Carpenter Helper  
Painter  
Painter Helper  
Plumber  
Plumber Helper  
Electrician  
Electrician Helper  
Refrigeration Mechanic  
Gardener  
General Helper  
Laborer

(Roofer, Sheet Metal Worker, Plasterer, Welder, Locksmith, as partial or complete jobs as indicated)

Laundry

Chief Laundryman  
Washman  
Extractorman  
Laundry Worker

Transportation

Machinist  
Automobile Mechanic  
Automobile Mechanic Helper  
Chauffeur

### Power Plant

Engineman  
Fireman  
Helper

### Fire Department

Chief Fire-fighter  
Fire-fighter

### Civilian Guards

Chief Guard  
Guard

### Miscellaneous Administration

Chief Telephone Operator  
Telephone Operator  
Elevator Operator  
Janitor  
Maid (Quarters)  
Maid (Dependents Service)  
Librarian

### Miscellaneous Clinical (possible civilian positions)

Occupational Therapist  
Physio-Therapist  
Laboratory Technician  
X-Ray Technician

A normal position analysis study probably would require two independent job analyses and two verifications of each job. Three competent analysts should complete such a study in three months. The cost would probably be approximately \$7,500.

Maintenance of the job analyses can readily be handled by the civilian personnel branch of the Bureau. The original survey should be conducted by a team which should include a representative of the Bureau.

While position descriptions have, in the past, been used primarily for wage and salary evaluation, they are of basic importance for the other personnel functions, particularly employment and placement, reduction in force, efficiency rating, and training. They are the only written statements of what work is expected of an employee.

Excess Employees in the Higher Grades, and Excess Supervisory Employees: Many employees are paid for higher classifications of work than they are performing, thus creating a problem which requires positive action. Although effecting general reductions in rating or pay is one of the most difficult of all personnel tasks, such reductions are nevertheless indicated because of the serious morale problem caused by improper grading.



Psychologically, the best time to effect demotions is when their necessity is obvious to the employee, such as during reductions-in-force or major organizational changes. It is best to avoid pay cuts where possible, for example, by transferring workers to other positions. This method cannot be used extensively during periods of contraction such as at present. Sometimes it is feasible to effect reductions in rating at the time of a general increase in wage rates. This might be possible in a few occupations as a result of the wage survey being conducted by OIR.

The turnover of personnel will ultimately ease the problem somewhat, provided the vacated positions are not filled at the same rate of pay. In many cases, however, it will be necessary to demote. If this is not accomplished soon, the Bureau will be subject to criticism, since many employees are receiving higher pay than is appropriate for the type of work being performed.

Closely related to the above is the problem of excess supervisory employees. Some supervisors are performing no real function but merely confusing the organizational pattern. Their positions should be abolished. Many others are rated too high, e.g., an assistant foreman mechanic performs the duties of a head carpenter, or a steward performs the duties of a head cook. It is estimated that over \$100,000 can be saved by eliminating unnecessary personnel or reducing the grades of excess supervisory employees at the five hospitals alone.

Most commanding officers and top administrative personnel are aware of the existing conditions, but hesitate to take action because of the necessity for maintaining day-to-day relations with their employees. The hospitals would welcome Bureau support in solving the problem.

Highly effective liaison must be maintained between the Bureau and the field in order to carry out a demotion program. To this end, it is recommended that the Bureau assign a highly competent personnel officer to discuss this problem locally with each commanding officer, and to work out the organizational patterns and indicate where exceptions might be made. The instructions can be issued from the Bureau with the prior approval of each commanding officer.

The task is not an easy one, but the ultimate benefits to be gained by minimizing inequities will justify the time and trouble. Greater savings will be realized in increased production rather than through an immediate reduction in the number of positions.

Recruitment, Employment, and Placement: None of the hospitals studied has an effective employment program. Hospitals submit requisitions to labor boards who refer the workers to them. In effect, the labor boards do the hiring, since the hospitals rarely exercise rights of selection among these referred.

The hospitals do not specify proper minimum job requirements, and are not familiar with their own prerogatives in the selection and placement of workers. As a result of this lack of proper screening, the hospitals too often accept workers who are not thoroughly qualified, are inefficient, require considerable training, and do not fit into the pattern for successful hospital operation.

The hospitals do not understand basic in-service placement and promotion policies. For example, power-plant enginemen, in many cases, are hired from the outside rather than promoted from firemen. In some cases, it is because firemen were improperly selected originally, and could not attain the qualifications for enginemen. In other cases, hospitals did not know that firemen could be promoted after meeting the experience requirements. Similar cases exist throughout the maintenance division. Laborers are not generally considered when openings exist for chauffeurs or helpers in the various shops. Conversely, during reductions-in-force, chauffeurs with relatively high seniority were not given the opportunity to compete with laborers. Mess attendants and maids, or mess attendants and laborers, were not allowed to compete with one another, although none of these jobs require previous experience.

The lack of an effective employment and placement program results in poor performance, low morale, and high turnover. One of the best ways to combat turnover is through proper employment action since turnover is the highest, percentage-wise, among new employees. Equitable policies and promotions and reductions-in-force are basic for good morale. A personnel officer should be selected who is qualified particularly in placement work. The emphasis should be placed on his knowledge of principles, rather than familiarity with the paper work involved.

Supervisory Training: Another weakness in the hospital organization which affects administration appears to be at the first-line supervisory level. These supervisors include foremen and heads of units in the case of civilian workers, Hospital Corps officers in some administrative divisions, nurses in ward administration, and Medical Corps officers in some services. The supervisors seem to be competent in the technical aspects of their job, but are



noticeably poor in the leadership aspects, their knowledge of personnel administration, and modern administrative practices.

No training program is in operation at any hospital studied. In two hospitals, regular conferences are held between the commanding officer and the division heads, but they are concerned mostly with technical problems without ultimately reaching many of the operating supervisors. At San Diego, weekly conferences are held by the foreman mechanic with his section heads. The results were gratifying, but the foreman mechanic readily admitted his weaknesses in many aspects of personnel administration due to the lack of professional guidance.

It has been said that half of a foreman's time should be spent on personnel problems, i.e., employee relations, training, placement, and controlling worker output. Yet the foremen have not had the opportunity to learn this phase of their job. Most of the present supervisors were promoted during wartime and their training was, perhaps necessarily, neglected. Generally, the foremen realize their weakness and are anxious to learn, but find themselves hindered by lack of guidance. For the next two years, at least, emphasis should be placed on supervisory training.

The establishment of a training program for the average line-employee is not justified. Informal on-the-job training by the supervisor is probably the better method.

A full-time training officer position is not warranted for the average hospital. However, supervisory training should be one of the primary responsibilities of the personnel officer.

Efficiency Rating: The original purpose and great value of efficiency rating is obscured in naval hospitals (as in most government agencies) through poor administration by rating officials. There is a lack of consistency in the rating officials' understanding of the terms "good", "very good", and "excellent". Most ratings are entirely too high. Most employees feel slighted with a rating of "good", whereas, by definition, a "good" employee is performing an entirely adequate job and is supposedly the average employee.

The operation of the efficiency rating system has been criticized widely throughout the federal service, and hospitals cannot be expected to lead the way in necessary reforms. However, in too many instances, hospitals have failed to comply with basic laws and regulations governing efficiency ratings. For example, efficiency rating often is not conducted on time. The supervisory employees are not given adequate notice, and must prepare ratings in



one or two days. The efficiency ratings are rarely discussed with the employees, and many employees are not familiar with their right to appeal.

Efficiency rating has considerable value, even if negative. The efficiency rating is the fairest and most logical means of removing inefficient employees. It is a written statement showing wherein the employee has met, or failed to meet, the job requirements. In the past, hospitals desirous of removing an employee because of inefficiency have found, to their embarrassment, that the employee was rated "very good" or "excellent."

Improvement of efficiency ratings can be achieved best by supervisory employees through a better understanding and proper administration of the efficiency rating system. Such training requires the services of a competent personnel officer.

Employee Relations: Another shortcoming in personnel administration is the lack of an effective means by which an employee can be heard, or conversely, how he can be reached. There is no operating grievance procedure. There is no one to whom the employee can unburden himself with any confidence that action will be taken. Supervisory employees occasionally go to the commanding officer, but the rank and file employee rarely does so.

As a result, many employees have a feeling of frustration in personnel matters, the "nothing can be done about it" attitude. Output is thus seriously affected. The tendency of many employees is to take personal advantage of everything they can, so typical where good employee relations are lacking. Loyalty is given to individuals, rather than to management (the Government).

It is unfortunate that we do not know how to measure morale accurately. But output and quality of performance could be vastly improved by good employee relations. Effective personnel administration in the Medical Department will go a long way toward reaching that goal.

A good foreman can do much in employee relations. However, even among good foremen there can be no consistency in actions on grievances, disciplinary problems, and in the interpretation of personnel policies, without central direction. Management (the staff and top supervisory employees) also suffers greatly from lack of professional advice about employee relations. Management is aware of some of the changes in employee-employer relations over the past years, but is not sufficiently familiar with current practices to be thoroughly cognizant of its prerogatives. It is overly apprehensive of the method of assigning work due to the fear of violating trade practices, and confusion exists regarding the difference between work assignment and wage practices. Position classification is somewhat of a



mystery. No consistent disciplinary policy exists as a basis for action on inefficient employees, while, in contrast, gross firings have occurred for little or no reason. Shrewd employees have taken advantage of the lack of knowledge on the part of management. If labor unions enter the picture to any extent, management will be at a great disadvantage in dealing with them.

Civilian Personnel Records: There is no consistency in the maintenance of civilian personnel records. No hospital studied has a complete file. One hospital has no personnel records, these records being maintained by the local labor board. Two others maintain files on efficiency ratings and classification sheets but no employment data. Basic data such as wage rates is lacking in some cases.

Complete personnel records are an integral part of an effective personnel administration program since they are the basis for effective personnel actions. The lack of centralized records has impeded actions in the past, particularly in wage administration, reduction-in-force, and placement.

Three simple, basic files are necessary: (1) a file of complete personnel jackets, (2) a visible card file of employees, and (3) a file of position descriptions and wage classifications.

The personnel jacket should contain a complete documentary record of each employee. This will provide basic reference information for active employees and a permanent record of separated employees. The standard jacket prescribed by the Civil Service Commission should be used. Hospitals should immediately undertake to collect all outstanding information on each employee including employment data, placement actions, training, wage data, and safety records.

A visible card file of employee data is necessary to provide a convenient current record on active employees, answer inquiries, simplify the preparation of reports and personnel inventories, serve as a tickler for such items as periodic pay increases, efficiency ratings, probationary and temporary appointments, and particularly, to serve as a control record. A standard personnel record card essentially the same as used in the Bureau, is suggested (Exhibit 4).

A third file of position descriptions for classified employees and of job definitions for unclassified employees is necessary to provide an accurate statement of the duties for each position. This file should be incorporated with the visible card file to show the

position and employee data.

Both the visible card file and the position file should be arranged by organizational units rather than alphabetically.

Accumulation of Annual Leave: Civilian employees have accumulated an excessive amount of accrued annual leave. The average leave per employee is 42 days. It is estimated that about \$75,000 should be held in escrow for annual leave. Nearly \$150,000 is earmarked for annual leave at San Diego. Approximately 10 to 15 percent of the annual budget for civilian employees is in annual leave already earned.

Where budget limitations force a reduction in civilian personnel, lump sum annual leave payments may force more reductions than would be ordinarily necessary, since these payments are often made in the following fiscal year.

Some naval districts are apparently aware of these potentialities, and have sent letters to the naval establishments suggesting that civilian employees be urged to take annual leave. However, no one, including district headquarters, seems to know if civilian employees can be forced administratively to take annual leave or if the matter is optional with the employee. The civilian employees themselves are to a large extent aware of this uncertainty. Many, particularly those who are likely to be caught in a reduction in force, are reluctant to take leave, preferring to build up the lump sum annual leave payment as a form of unemployment compensation.

The scheduling of annual leave is, and always has been, purely a management prerogative, suited to the desire of the employee when circumstances permit. Because of the accumulation of annual leave, it is now necessary that this prerogative be exerted.

Instructions should be issued by the Bureau that annual leave for civilians be reduced to a maximum of 30 days, and that leave above 30 days shall not be permitted to accumulate.

Safety Function: The safety function is listed as part of the duties of the personnel officer in paragraph 1512 of the Manual of the Medical Department. However, at all hospitals studied, the maintenance officer performs a collateral duty as safety officer. This duty, if performed at all, takes a considerable amount of time, and at least one hospital employs an additional part-time safety inspector. The bulk of the time spent on the safety function consists of clerical work, i.e., safety publicity and many routine and special reports. Separate files of accident reports are kept in the maintenance office, but no accident record is filed in the employee's official personnel jacket.



The safety program in industry usually comes under the cognizance of the personnel department, not only because it is an activity which concerns employee welfare, but also to avoid duplication of records and reports.

It is proposed that clerical work on records and reports pertaining to the safety program be assigned to the civilian personnel section. However, the more technical safety inspection function should remain as a collateral duty of the maintenance officer. This arrangement will require close collaboration between the personnel office and the maintenance office in all matters pertaining to safety.

#### RECOMMENDATIONS

1. The civilian personnel program outlined in paragraph 1512.2 of the Manual of the Medical Department should be activated in all hospitals. The civilian personnel officer should be responsible to the personnel officer.
2. The complement for the civilian personnel section should be established at 1 percent of the total civilian employees.
3. A personnel officer (civilian) who is professionally qualified in all phases of personnel administration, particularly in regard to wage administration and employee relations, should be placed in charge of the civilian personnel section.
4. A complete job analysis of all unclassified and many classified hospital occupations should be made by the Bureau immediately. From these job analyses, a comprehensive wage pattern should be established. The resultant job descriptions should be used for other phases of personnel administration, particularly employment and placement.
5. The civilian personnel officer should explain to all employees the meaning and method of classification and job grading.
6. The problems of excess employees in supervisory positions and of employees improperly graded should be solved by eliminating inequities at times of wage increases or during reduction-in-force, by replacing employees voluntarily separated with properly rated employees, and, where necessary, by demotions. Where it is necessary for hospitals to demote employees, the Bureau should issue directives to commanding officers authorizing such action. The quotas for each type of position should be developed locally by the

commanding officer and a Bureau representative, and the necessary directives issued. Effective liaison between the Bureau and the hospital must be maintained for these actions.

7. Effective employment, placement, and efficiency rating programs should be activated by the civilian personnel officer. More emphasis should be placed on in-service placement and promotions. Grievance procedures should be established and made known to all employees.
8. A supervisory training program should be initiated and conducted by the civilian personnel officer.
9. Personnel records should be standardized and centralized in the civilian personnel section. The basic files should consist of: (a) complete documentary records pertaining to the employee as included in the standard personnel jacket, (b) a visible summary card file of employee data, and (c) a file of position descriptions and job definitions.
10. Accumulated annual leave for civilian employees should be immediately reduced to a maximum of 30 days; once reduced, leave should not be allowed to accumulate beyond 30 days.
11. The clerical work on records and reports pertaining to the safety program should be assigned to the civilian personnel section. However, the more technical safety inspection function should remain as a collateral duty of the maintenance officer. This arrangement will require close collaboration between the personnel office and the maintenance office in all matters pertaining to safety.



## PERSONNEL RECORD

MEDICINE &amp; SURGERY — NAVY DEPT.

NAME \_\_\_\_\_

20 30 40 50 60  
 TYPIST PLEASE NOTE — START ALL TYPING AT SAME POINT ON SCALE. THEN REMOVE THIS STUB. BE SURE YOU HAVE A WELL  
 INKED RIBBON. CARE USED IN TYPING WILL IMPROVE REFERENCE DURING THE ENTIRE LIFE OF THE INDEX. TRY A FEW IN THE  
 POCKETS TO SEE HOW THEY LOOK BEFORE TYPING THE ENTIRE LIST. FOR UNIFORMITY IN STOCK AND PRINTING, ALWAYS USE  
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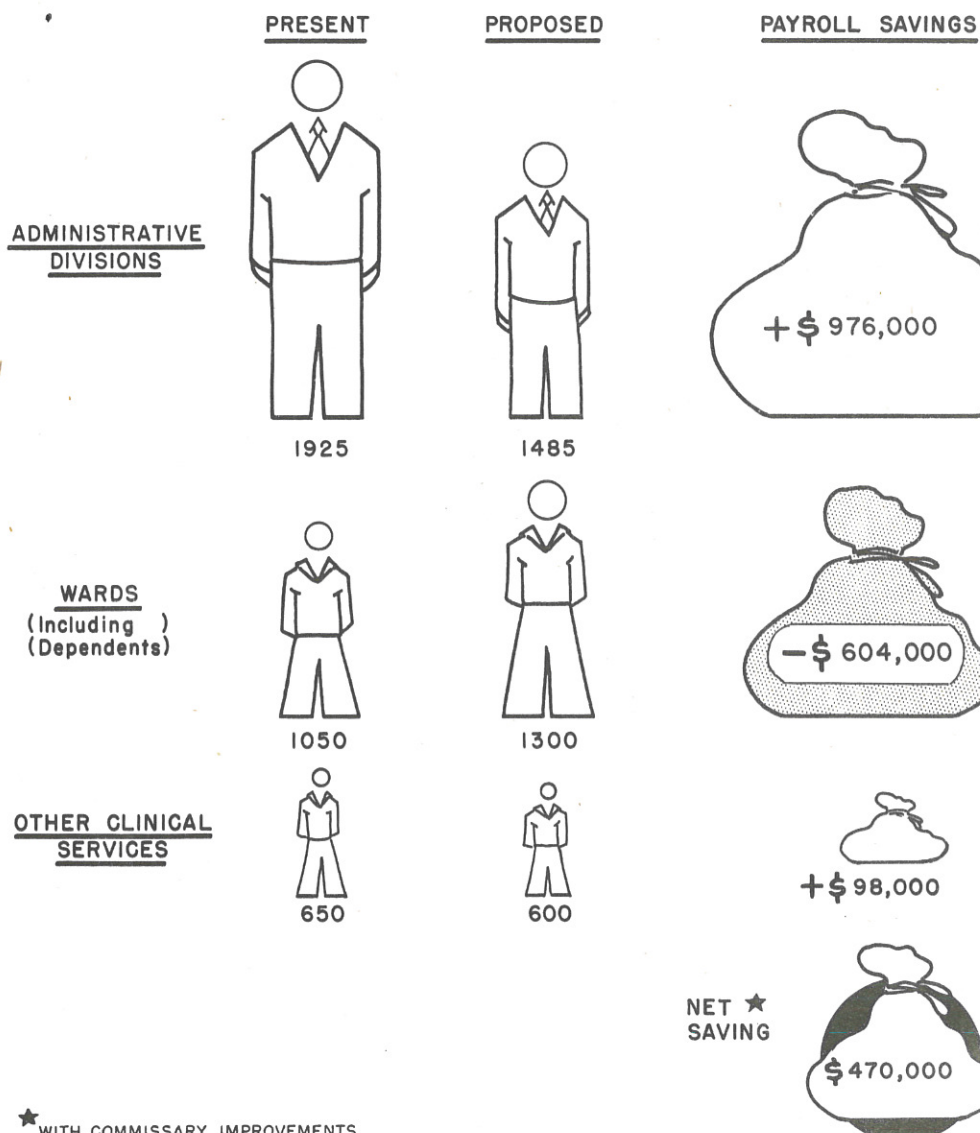
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#### IV WORK MEASUREMENT AND STAFFING REQUIREMENTS





# TOTAL STAFF REQUIREMENTS FOR THE FIVE HOSPITALS



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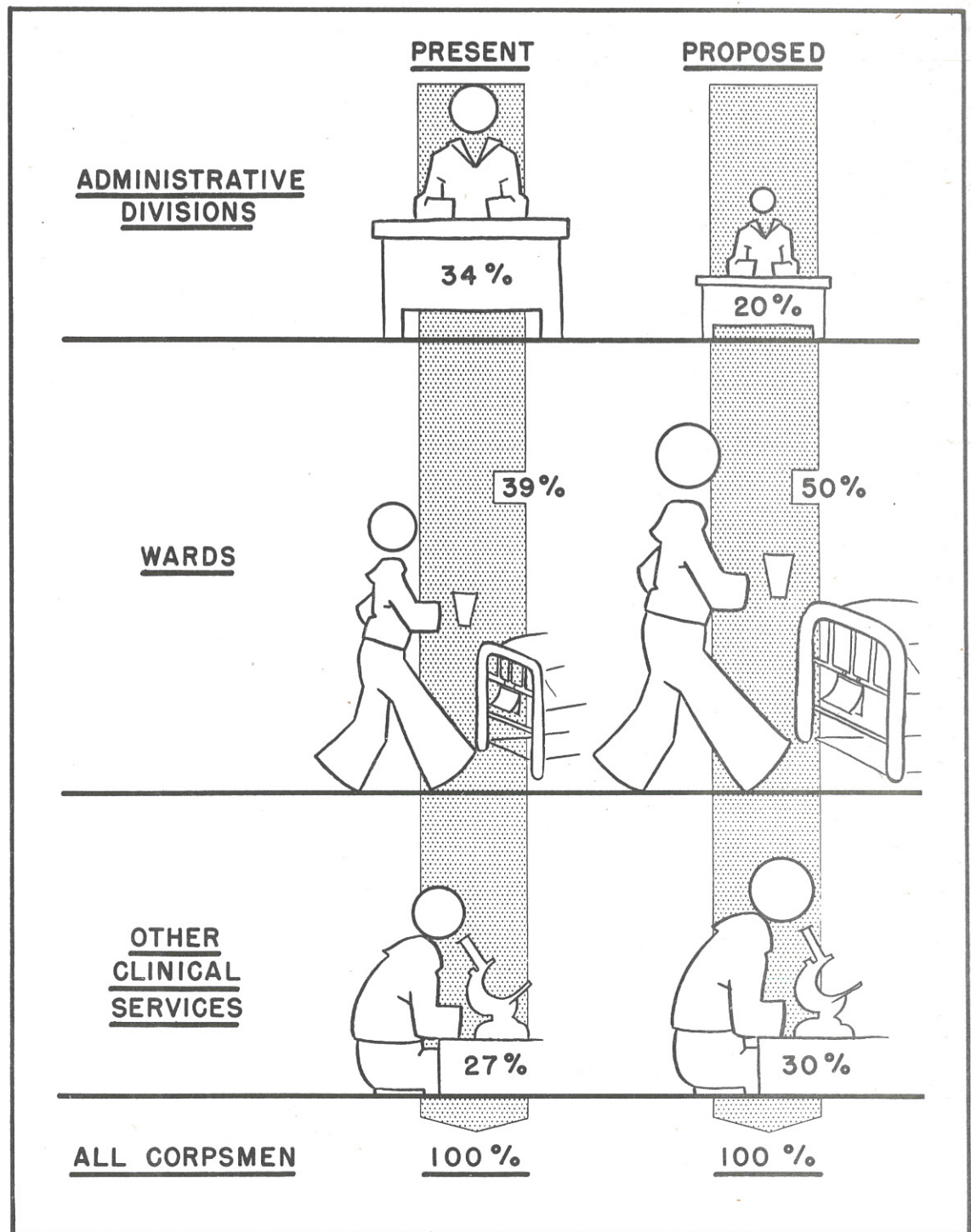
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## WORK MEASUREMENT AND STAFFING REQUIREMENTS

The hospitals question the method by which personnel were reduced beginning early in the summer of 1946. There was apparently little relationship between staff reductions and the drop in patient load, and practically no coordination between allowances for the military and civilian staff. The opinion prevails that very little consideration was given local conditions, particularly overhead requirements. The hospitals consider the liaison between the Bureau and the field to be particularly ineffective in respect to staffing requirements.

Expense analyses show that the military and civilian payrolls represent about 75 percent of the total operating costs of a naval hospital. It is important, therefore, that the staff is no larger than is required to accomplish the work requirements. It is equally important that the staff is sufficient to meet the standards of service in all the divisions and services. Statistics gathered on staff and patient load indicate that, even at present, there is little relationship between the staff assigned and the work to be done.

Because of the magnitude of the problem, the survey team devoted considerable effort to the establishment of a consistent relationship between the amount of work to be done (basically, the patient load) and staff requirements.

Work Measurement: Because of the nature of hospital work, it was necessary to determine (1) if administrative and clinical organizational units would lend themselves to work measurement, (2) if suitable work load indicators could be found, and (3) if staffing requirements could be accurately related to these work load indicators.

The survey clearly indicates that the answers to the above questions are all in the affirmative, and that staffing requirements can be accurately predetermined for individual hospitals according to the patient load.

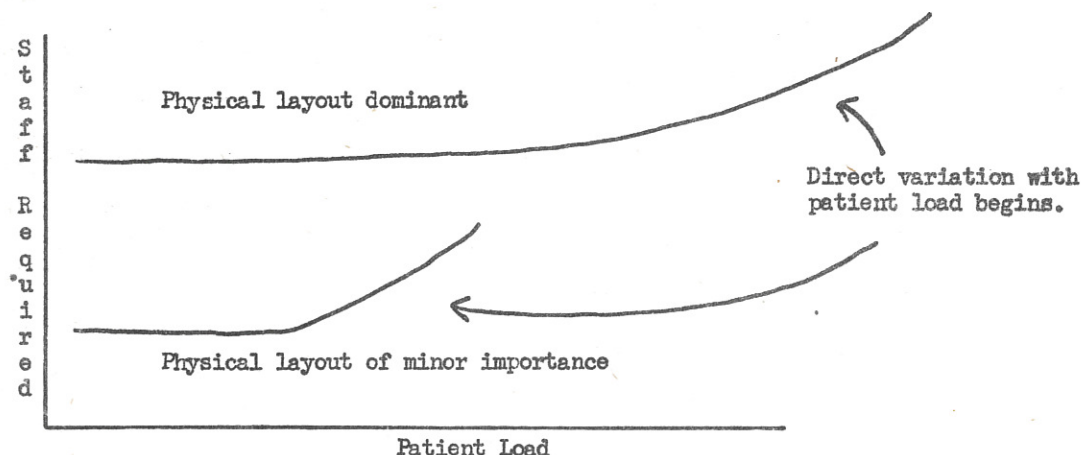
Relationship between Patient Load and Personnel Overhead: Personnel overhead is the minimum staff necessary to operate an organizational unit regardless of the volume of work. Practically all units have a considerable overhead factor, which is dominant in determining staff requirements at low patient loads, but gradually loses significance as the patient load increases.

Physical layout is of great significance in such organizational units as the commissary division and the shops and grounds section of the maintenance division. Overhead remains dominant up to a high point in patient load in these activities. In others, such as the power plant or telephone section, the overhead factor is dominant to, and beyond, the capacity of



the hospitals. In those units where physical layout is of little significance, the overhead factor becomes of minor importance at a relatively low point in patient load.

The following graph illustrates the variations in staff requirements relative to the patient load for different types of organizational units.



Conclusions concerning the Feasibility of Standard Staffing:

1. Where the physical layout of organizational units is of little importance, staff requirements vary directly with the patient load. If the same basic procedures are used, this variation should be the same for all general hospitals. Hospitals of the same size should have the same staff in the following activities: finance, personnel and patient records, disbursing, laundry, all the professional services, and probably transportation.
2. Where the physical layout of organizational units is important, staff requirements will vary from hospital to hospital, but can readily be determined for each hospital. The variation with patient load beyond the point where the physical layout is dominant is the same for all hospitals. Physical layout is a particularly significant factor in the commissary division and the shops and grounds section in the maintenance division. These activities represent from 25 to 30 percent of the total staff and over 50 percent of the civilian staff. Staff requirements for the fire department, civilian guards, elevator operators, and janitors should also be justified on an individual hospital basis.
3. Staff requirements for the power plant and telephone section do not vary with patient load, but should be the same for all hospitals where the equipment is similar.

4. The conclusions listed above show that it is feasible to establish staffing patterns for individual organizational units within a naval hospital.

Work Load Indicators: A work load indicator is basically a yardstick for measuring the work to be done. For example, the pieces of laundry handled per month is a work load indicator for a laundry.

The basic work load indicator for hospitals is the patient load. From this point, work load indicators for individual organizational units (Table 1) are intermediate steps in arriving at staff requirements.

For example, to determine staff requirements for a laundry, it is necessary to know first how many pieces of laundry per month can be handled by a worker. If the standard is established at 7,000 pieces of laundry per worker per month, then a work load of 150,000 pieces of laundry per month would require approximately 22 laundry workers.

To relate laundry workers to patient load, it is necessary to know how many pieces of laundry can be expected at various patient loads. The statistics which are very reliable for laundries, show that at a patient load of twelve hundred, 125 pieces of laundry per patient per month can be expected, or a total of 150,000 pieces of laundry for the month. If the standard is 7,000 pieces per laundry worker per month, the laundry workers required would be 150,000 divided by 7,000, or 22 laundry workers for 1200 patients.

The work load indicator not only enables the establishment of standards of performance per worker, but also serves as a check on whether total production is normal for the particular patient load.

To illustrate, let us assume that 10 laboratory examinations per patient per month is normal, or a total of 10,000 examinations for 1000 patients. If a 1000-patient hospital reports 15,000 laboratory examinations, then the reason for the abnormality should be determined. The excess examinations may be justified by a special service, as at Philadelphia, where a veteran out-patient clinic is operated. The laboratory staff should be augmented accordingly. If another hospital reports only 5000 laboratory examinations, it is entirely possible that the laboratory is not providing adequate service.

Work load indicators should reflect the total volume of work to be done, although they need not measure all of this work. For example, total pieces of laundry is all the work to be done in a laundry. The total number of radiographs, however, is not all the work done by the X-ray service, but it does reflect the total work in that the volume of the other work done is generally proportionate to the variations in radiographs.



Work load indicators should require no extra reporting. They should tie in with normal production reports.

Unfortunately, it is not always feasible to obtain adequate work load indicators so that the end justifies the means. As an example, the survey team was not successful in developing work load indicators for the finance division or the shops and grounds section of the maintenance division. The staff requirements are related directly to patient load for finance, while an empirical formula is used to establish the staff required for the shops and grounds.

Statistics on Organization Units: Considerable statistical information was gathered on the performance of individual units at the hospitals studied. The performance of each unit is discussed in more detail in the sections of the report devoted to the various divisions and services.

The total volume of work performed shows remarkable consistency with the patient load in such administrative units as laundry, commissary, shops, transportation, and in professional services such as X-ray, EENT, laboratory, dental, and the main operating room. In each of these cases, it is practical to determine expectancies, such as the total number of pieces of laundry, rations served, work repair requests, X-ray examinations, visits to the EENT clinic, laboratory examinations, operations, and dental sittings. All of these varying consistently with the patient load. Actually, this is as it should be, because the five hospitals perform similar functions and the proportion of in-patients in each professional service is approximately the same (Table 2). Where variations exist, they are due either to extra services provided, as at Philadelphia, or incomplete services.

In some units, good indicators of total volume of work, other than patient load, are either lacking or impractical to use. Such units are finance, and personnel and patient records. In other units, personnel overhead so dominates staff requirements that work load indicators are of minor significance in determining staff requirements. Such units include welfare and recreation, power plant, grounds, fire department, civilian guard, telephone, library, pharmacy, and overhead staff (other than for wards) for services as medical, neuro-psychiatric, physical medicine, urological, etc.

The amount of work performed by the individual worker shows little consistency among hospitals. However, statistics provide sufficient information to determine the amount of work that could be accomplished under favorable circumstances. Statistically, the standard of performance is, in general, established at the upper quartile point - that is, roughly 25 per-



cent of the months show performance exceeding the standard. However, the standards were thoroughly discussed with the particular divisions and services concerned. Adjustments were made, usually upwards, as a result of their recommendations. For example, statistics on laundry worker performance for a combined total of 67 months at five hospitals. Production exceeded 7,000 pieces of laundry per worker per month for 21 of the 67 months, but was as low as 3,000 pieces per worker some months. Observations indicated that when production was about 7,000 pieces, production was smooth and the workers busy without being overloaded. Therefore, a standard is established at 7,000 pieces of laundry per worker per month.

It must be emphasized that the standards established are tentative and should not be considered as fixed. Technical improvements or changes in policy change any standards, no matter how accurate they may be at the moment. Based on present policies and procedures, most standards proposed in this report can be considered accurate to within 10 percent. It is more important that some standard be established and used, than the standard itself be highly accurate initially.

Proposed Standard Staffing for the Hospital as a Whole: The proposed standard staff requirements for individual organizational units are summarized in Table 3 to present a complete picture of staffing requirements in an "ideal" or "standard" hospital. Functions not normally found at a hospital, such as a veteran out-patient clinic or aural rehabilitation clinic require a staff over and above that indicated in the table.

The staff of the commissary is based on an ideal layout for the various patient loads, which does not exist at any hospital. The staff for the shops and grounds section is based on a typical expectancy, since individual hospitals vary in square footage and acreage. Individual hospitals may also vary in such organizational units as the fire department, civilian guard, elevator operator, telephone, janitor, and power plant.

Tables 4 through 8 show the differences in proposed standard staffing for the individual hospitals studied, and the "ideal" proposed standard staffing. These differences are due either to physical layout, as the commissary and shops and grounds, or to a combination of physical layout and function, as the fire department, civilian guards, telephone operators, janitors, and elevator operators. In summary, these tables show the staff requirements by organizational unit for each of the five hospitals.

Past Staff Distribution; Tables 60 through 64 in Appendix II show the total staff distribution, month by month, since January, 1946. A study of these tables brings to light incon-



sistencies in total staffing, staff-per-patient ratios, (Table 9) staffing of the individual organizational units, and the relative percentage of civilian and military personnel. Table 10 shows past staffing of medical and dental officers and the patients per officer ratio.

Staffing Curves: Curves have been developed for each hospital showing the actual staff per patient ratio, as indicated by past performance, and the proposed staff per patient ratio (Exhibits 7 through 11). An additional curve, indicating the average staff per patient ratio versus the patient load, has also been prepared (Exhibit 6).

Because payrolls represent about 75 percent of the total cost of operating a naval hospital, the cost per patient day varies almost directly with the staff-per-patient ratio. Therefore, the curve showing the variation of staff-per-patient ratio with patient load also reflects the variation in cost per patient day with patient load.

All "variation of staff" curves show a sharp drop in staff as a result of the complement cuts during the summer of 1946. The curves for Portsmouth, Great Lakes, and San Diego show the normal trend. The patient load and staff were dropping, but staff reductions did not keep pace. There is a well-defined rise in staff-per-patient ratio with the drop in patient load, the actual rise being considerably above the proposed staff-per-patient ratios. Each of the three hospitals was overstaffed considerably in early 1946, approached the standard at the time of the cut, but veered up again as the patient load continued to drop. Portsmouth shows a cost of approximately \$2.00 per patient day above the proposed standard, Great Lakes \$1.50 and San Diego about \$1.00.

Philadelphia shows the same beginning trends as the other three hospitals, the staff and patient load dropping together. However, in the winter of 1946-1947, the patient load stabilized, while the staff continued to drop and rapidly approached standard staffing. (Exhibit 11)

Newport typifies understaffing. The same initial trends are noted - staff decreases follow the patient load very closely. However, the reductions in staff came at about the same time the patient load stabilized, resulting in serious understaffing. Obviously, the expected patient load had been miscalculated because of military considerations, but corrections in complement were not made. The patient load at Newport became stabilized from four to six months before the other hospitals. Careful investigation at Newport disclosed the serious personnel shortage. The other hospitals are short in ward personnel, sufficiently staffed or overstaffed in the other clinical services, and generally overstaffed in the administrative divisions. Newport is the only hospital understaffed in the administrative



divisions as well as the other services. The abnormally low staff-per-patient ratio highlights these shortages.

Meaning of Curves: The curves indicate clearly the rise in cost per patient day with the drop in patient load. Moreover, the rise is not a straight line, but accelerates with the drop in patient load as the personnel overhead factors increase in significance. The curves break so rapidly at low patient load that it becomes undesirable to operate the hospital from the standpoint of cost. It should be noted that this point varies from hospital to hospital, depending on the overhead factors. For example, a staff-per-patient ratio of 1.0 is required for 430 patients at Newport, whereas for the same ratio at Portsmouth, the patient load is 560 patients.

Overstaffing is much more significant in terms of cost per-patient-day at low patient loads than at higher loads. An excess staff of 50 employees would increase the cost per-patient-day at San Diego (1350 patients) only about \$.30 whereas at Portsmouth (460 patients) this same excess staff would result in an increase of over \$1.00 per-patient-day. The curves show that the lower the patient load, the greater will be the departure of actual staff-per-patient ratio from the proposed staff per patient. Since it is expected that patient load will continue to drop, the necessity for closely controlling staff in order to control cost per patient day, will become increasingly important.

The average patient load for naval hospitals is now between 500 and 550 patients. This is about at the critical point on the staffing curves, where the cost per patient day increases very rapidly with further decreases in patient load. To avoid excess costs, the actual staff-per-patient ratio curves must be shifted to the left, i.e., reduce the point below which it becomes uneconomical to operate a hospital by increasing its patient load. This can be accomplished only by increasing the number of veteran patients or eliminating other hospitals.

Methods of Reducing Staff Requirements: Effective complement control and the reduction of personnel overhead are steps that can be taken to reduce staff requirements at low patient load. The reduction of overhead can be obtained by improvements in physical layout and the consolidation or elimination of functions.

Effect of Physical Layout on Staffing Requirements: Physical layout is a basic consideration in determining personnel requirements. Hospital buildings, in general, are scattered, and services decentralized within the buildings. All ward corpsmen make daily visits to such



units as pharmacy, central surgical supply, laboratory, X-ray, personnel, commissary, and laundry, yet these units, particularly the adjunctive clinical services, are scattered throughout the hospital.

The individual organizational units are often physically separated. The commissary division, the largest of all organizational units, is not centralized in any of the five hospitals. The use of one galley and centralized storage facilities at San Diego would effect personnel savings of over \$150,000. A capital investment for plant modifications would be necessary, but would pay for itself in less than two years.

Activities are dispersed. Two or more pharmacies exist in a single hospital, and there is a general dispersal of X-ray facilities, personnel division functions, libraries, and laundry and linen room. While the usual layout makes the centralization of all operations impractical, nevertheless great personnel savings can be effected by consolidating and compacting all the activities within an organizational unit.

Maintenance would be greatly facilitated by de-activating many buildings now in use. Excess floor space is a problem not only for the civilian maintenance force, but for military personnel who service their own area. In many cases, it appears that it would be better to demolish old buildings completely in order to save maintenance personnel, eliminate excess heating costs, and reduce fire hazards.

Hospital Design: It is doubtful if hospitals have been designed to give as great consideration to complement as is necessary today. The relative significance of payroll costs in operating a hospital is greater now than it has been in the past. Annual operating costs of hospitals in general and government hospitals in particular are more significant than the capital investment in buildings and equipment.

Naval hospitals, such as at San Diego, Portsmouth, and Great Lakes, are not well laid out in terms of personnel utilization. Skyscraper hospitals are an improvement, but there has been considerable criticism concerning their usefulness as a military hospital. Their chief weakness seems to be that they are inefficient to operate much above or below their rated bed capacity. Above capacity, adjunctive services in the main hospital become overloaded and act as bottlenecks. Below capacity, the economic burden of overhead is too great. The Philadelphia hospital is an example of overloaded facilities which cause the "mushrooming" of adjunctive services. The services in the main building, particularly elevator service, are totally inadequate. Skyscraper construction may work out well for civilian hos-



pitals with a relatively constant patient load, but it is not well adapted to rapid expansion.

One type of design suggested for consideration by hospital architects is a "hub and spoke" type of arrangement. The main hospital units would be located in a large hub, and the spokes would comprise the wards. The dependents and out-patient service would be located in one or two of the spokes. Services such as the pharmacy, laboratory, X-ray, etc. would be located at the inner end of the dependent's service, and accessible to both the out-patients service and the main hospital. Centralized adjunctive services would eliminate many time-consuming trips now required of staff personnel. Administrative offices, the commissary, operating rooms, and other services would be located in the hub. This arrangement would greatly simplify the food and laundry delivery problems. Buildings outside the main structure would include the maintenance shops, garage, staff quarters, main storeroom, power plant, and laundry. A two-deck hospital with 10 spokes would provide a capacity of over 600 beds. An increase of one deck would raise the capacity to 1000 beds. The capacity of the hospital could be doubled or tripled by adding to the length of the spokes or, if necessary, superimposing additional decks.

Regardless of the design employed for the construction of a naval hospital in the future, special emphasis should be placed on staffing requirements and possible expansion in the event of an emergency.

Elimination of Functions: As hospitals decrease in size, certain necessary overhead functions should be eliminated or combined with those at other naval activities in the area, where possible. Some hospitals have already done this, but the problem will become more significant in the future as the patient load drops.

Newport and Great Lakes, for example, use the telephone service provided by adjoining training stations. Great Lakes pays a proportionate share; in this case, for two telephone operators as compared with six if they provide their own service. Newport's fire protection is provided by the training station. At Great Lakes, sufficient steam could be provided by the training station for the hospital, at least six months of the year, if the steam line running from the center to the hospital were utilized. In smaller hospitals, it might also be possible to eliminate the independent maintenance and laundry functions and thus effect further savings.

Reduction of Overstaffing: Close control of personnel allowances is of prime importance, especially as the patient load decreases.



Table 11 shows the theoretical excess staff in the hospitals studied as compared with the proposed standard staff requirements in Table 3. It is apparent that most of the personnel surpluses exist in the administrative divisions. The only activity in the administrative division where there is a consistent personnel shortage, is the security force; caused basically by a lack of sufficient guards for prisoners. However, noticeable shortages occur in the wards and the dependents' service.

Table 12 shows the percentage of past distribution of total staff between clinical services and administrative divisions. According to the latest statistics, the administrative divisions average 55 percent of the total hospital staff. There are also numerous administrative positions in the clinical services which are difficult to account for statistically. More significantly, this percentage had shown a rise of 10 percent as the patient load dropped from January 1946, when the percentage of personnel in the administrative divisions was only 45 percent. The trend clearly indicates that this percentage will continue to rise as the patient load decreases.

Table 13 shows the past distribution of corpsmen between administrative divisions, wards, and other clinical services. This table emphasizes the high percentage of corpsmen in administrative divisions.

Table 14 shows some striking differences in the proposed standard staff and complements in the past.

The proposed standard staffing tables contemplate not only a considerable net savings in payroll, but more important, a shift of personnel from the administrative divisions to the clinical services, particularly the wards (Exhibits 5 and 12). This can be accomplished in several ways. Personnel surpluses can be reduced by shifting corpsmen to the wards, and utilizing civilians in the administrative divisions insofar as practical. More corpsmen in the clinical services can be made available for ward duty by using civilians for such positions as ward galley workers, receptionists and clerks in the clinics, and as laboratory technicians.

Consolidation of Hospitals: One of the simplest ways of reducing overhead is by consolidating hospitals. The savings which result from placing the same total patient load in one hospital rather than two hospitals are considerable, particularly as the total patient load decreases. Savings can be made from 24 percent to over 50 percent at low patient load for the most efficient hospitals. At the average naval hospital the savings would be considerably greater,



averaging from 50 percent to 75 percent.

This is graphically presented in the accompanying curve "Comparison of Costs in Operating Two Hospitals Versus One Hospital at the Same Total Patient Load" (Exhibit 13).

Balancing Patient Load Between Two Hospitals: For reasons other than economy it is sometimes necessary to operate two hospitals in an area rather than one. The method of distributing patient load between the two hospitals will affect the staff requirements considerably. The proper distribution of patient load becomes most significant when savings on civilian payroll are paramount, because the overhead factors caused by physical construction and layout are chiefly reflected in the maintenance and commissary divisions.

A series of curves have been plotted of the staff requirements for different patient loads distributed between two theoretical hospitals. Each of the curves represents total staffing requirements through all ranges of percentage distribution of the particular patient load. The minimum point of each curve becomes the percentage distribution to give minimum staff requirements.

The accompanying curve "Sample Recommended Distribution of Total Patient Load Between Two Hospitals of Different Overhead for Minimum Staff Requirements" demonstrates the ideal distribution (Exhibit 14).

For example, for the 1300 patient-curve, a distribution of 48 percent of the patients (624) in Hospital #1 and 52 percent (676) in Hospital #2 would require a combined staff (civilian and military) of 1060; whereas if 65 percent (845) are in Hospital #1 and 35 percent (455) in Hospital #2, a staff of 1100 would be required. These additional 40 workers, chiefly civilian, would add more than 10 percent to the civilian payroll.

At a combined patient load of 800 patients, 60 percent of the patients (480) in Hospital #1 and 40 percent (320) in Hospital #2, would require a total staff of 885; whereas a more appropriate distribution of 35 percent (280) in Hospital #1, and 65 percent (520) in Hospital #2 would require a total staff of 835 or a saving of approximately 15 percent in the civilian payroll.

Below is a chart showing the recommended distribution of patients at various combined patient loads for minimum staff requirements for the sample hospitals chosen.



Distribution for Minimum StaffRecommended Distribution for Minimum Staff

<u>Total Patient Load</u>	<u>Hosp. #1 Percent</u>	<u>Hosp. #2 Percent</u>	<u>Hosp. #1 Patient Load</u>	<u>Hosp. #2 Patient Load</u>
1600	46	54	600 - 900	700 - 1000
1500	47	53	550 - 850	650 - 1000
1400	48	52	500 - 800	600 - 900
1300	49	51	450 - 700	600 - 850
1200	48	52	400 - 600	600 - 800
1100	45	55	350 - 500	600 - 750
1000	41	59	300 - 450	550 - 700
900	38	62	250 - 400	500 - 650
800	34	66	200 - 300	500 - 600
700	32	68	150 - 250	450 - 550
600	30	70	150 - 200	350 - 500

Similar binary curves can be developed for any hospital to hospital comparison, or comparisons can be made for a series of hospitals. These curves would be most valuable for distributing patient load among several hospitals in any area, such as a large municipality. However, they are of value for the Navy in areas which have more than one hospital, such as the San Francisco - Oakland - Mare Island area. They would also prove of considerable value in the event patients are interchanged between Army and Navy hospitals.

Coordination of Military and Civilian Personnel Allowances: The staffing studies show that civilian and military staffing are so interrelated in the hospitals that complement control must be centralized. This is accomplished, in effect, by the executive officer. The fact that executive officers are involved in staffing problems almost daily and spend a great deal of their time on this problem attests to its importance.

The hospitals criticized the seeming lack of coordination at the Bureau level in establishing civilian and military complement. Perhaps, during the past 18 months, conditions were such that complement control was difficult. To provide an appropriate complement for the work to be done, it is necessary to consider the problem in terms of total staff, rather than arrive independently at the number of civilians and military required. Close coordination is so necessary that the responsibility for establishing both civilian and military allowances should be centered in one division in the Bureau of Medicine and Surgery.

Methods of Staff Control: The Bureau must have accurate reports of work load at the hospitals if it is to maintain effective staff control. It is important also that the reporting procedure be simple and accurate.

The Finance Division of the Bureau requires a quarterly report from the hospitals, "Recapitulation of Ledger Accounts", NAVMED-569 (Rev. 1-45). Section (4) of this recapitulation,



"Statement of Expense Analysis Register Accounts" provides an excellent bird's-eye view of the cost of administrative and clinical operations.

In breaking down the accounts, the form partially follows organizational lines, but in several cases groups of independent functions are combined. These accounts are as follows:

E-101	Administration
E-102	Wards
E-103	Operating Rooms
E-104	X-ray
E-105	Pharmacy
E-106	Laboratory
E-107	Laundry
E-108	Transportation
E-109	Maintenance, Buildings and Grounds
E-109-A	Power Plant
E-110	Commissary
E-111	Recreational Service
E-112	Occupational Therapy
E-	Dental Service

No distinction is made, however, under "E-101" regarding administration between activities such as finance, personnel and records, security (master-at-arms), telephone, elevator, and miscellaneous administrative services. It is difficult therefore, to make comparisons between hospitals.

E-102, Wards, includes such miscellaneous functional units as the EENT clinic, physiotherapy, dependents' service, and neuro-psychiatric service, as well as wards. Each organizational unit submits a monthly report to the finance office. Separate reports are submitted by EENT, physiotherapy, dependents' service, etc., as well as units already receiving separate consideration, such as the laboratory, X-ray, and pharmacy. These reports contain statistics on the total work performed, divided between in-patients and out-patients. Similar reports are obtained from the administrative divisions, such as total laundry handled, total vehicle mileage, etc. In practice, the finance division gathers and maintains its information on a purely organizational basis, consolidating its information only for purposes of reporting to the Bureau. Actually, more work is involved in consolidating the report, as called for, than presenting the information by organizational units.

The "Statement of Expense Analysis Register Accounts" also calls for statements of expenditures for both military and civilian pay. The Hospital Corps detail desk already maintains daily lists of the distribution of military staff for assignment purposes and for the preparation of the "HC-4". In some hospitals this desk also maintains the summary of military pay accounts for the Expense Analysis Register. It is recommended in another section



of the report that responsibility for military pay records be assigned to the Hospital Corps detail desk. In any case, all of the records are kept on an organizational basis.

These basic fiscal operations revolve around the functional organization of the hospital. Adjustment of the Expense Analysis Register accounts to fit the organization would therefore simplify the fiscal operations at the hospital level. The individual organizational units are already established on a uniform basis, and it is merely necessary to note them as they exist. Table 3 lists the normal organizational units. Blank spaces could be used for unusual services, such as the Aural Rehabilitation clinic and Veterans' Outpatient clinic at Philadelphia, which should be handled separately in an expense analysis.

With an organizational breakdown as a guide for the setting up of Expense Analysis Register accounts, this form will offer an excellent basis for staff control reports. Already included are columns for "pay, civil personnel" and "pay, military staff". The necessary work load information is also reported to the finance officer for the purpose of allocating outpatient costs properly.

A suggested modification of the Expense Analysis Register is attached (Exhibit 15). Additional columns for work load, the number of civil employees, and the number of military personnel are included in the modification.

The actual staff performing the work should be compared with the recommended standard for that amount of work to determine if significant overstaffing or understaffing exists. Further, comparison of the actual work load with normal expectancies, for the particular patient load will indicate any unusual considerations pertinent to an individual hospital.

For example, at a hospital with a patient load of 800, twenty-five laundry workers handle a work load of 300,000 pieces of laundry for the quarter. Their performance, then, is 4,000 pieces of laundry per worker per month, which is 3,000 pieces below the standard. This indicates considerable overstaffing, at a rate of approximately \$22,000 annually. The staff should be reduced by 11.

In another example, 25 workers, employed at a hospital with a patient load of 800, handle a work load of 500,000 pieces of laundry for the quarter. Their performance is 6,700 pieces of laundry per worker per month, which is reasonably close to the standard. However, the volume of laundry amounts to about 210 pieces per patient per month, which is greatly in excess of a more normal expectancy of 135 pieces. The excess cost of the high usage rate which amounts to about \$25,000 annually, warrants careful investigation by the hospital or,



if assistance is needed, by the Bureau.

In the laboratory, 12,000 examinations during the quarter for a patient load of 800 represents an average of five laboratory examinations per patient per month, which is far below the normal expectancy of 10 examinations per patient. This sub-standard performance should be called to the attention of the appropriate medical officer, who should determine if it is due to poor laboratory service, understaffing, or unusual circumstances.

Thus, the use of work load indicators is not only a means of establishing effective control, but an excellent method of checking on the quantity and, in many cases, the quality of work performed by the hospitals.

Use of Work Load Reports by the Hospital: Work load reporting was discussed at considerable length with the Hospital Corps officers, particularly at San Diego and Newport, the last two hospitals studied, after sufficient data had been gathered to indicate the general results.

These Hospital Corps officers recognized that there are large inconsistencies in staffing. Each pointed out, however, that he has no way of comparing the performance of his particular hospital with that of other hospitals. They also emphasized the difficulty of determining on the basis of only one hospital what performance should be. While hospital officials readily admitted that many of their requests to the Bureau for personnel have been excessive to place them in a good bargaining position, they complained that they have been unable to obtain what they considered to be sufficient personnel. In addition, they felt that the Bureau has not adopted a good complement standard which it uses uniformly for all hospitals.

Hospitals are generally anxious to do a good job in staffing. They want the proper tools to work with, and are especially desirous to know what is expected of them. At the present time they have no way of knowing whether their performance compares favorably with that of other hospitals or not.

The information obtained from individual hospitals on the Expense Analysis Registers should be made available to all hospitals. The data can be circulated to the hospitals on summary sheets. The benefit in improved liaison between the hospitals and the Bureau would more than justify the small additional expense. Hospitals can be expected to improve performance by themselves if they are given a basis for comparison.



Use of Work Load Reports for the Personnel Budget: The advantages to hospitals of using factual work load reports for justifying their personnel needs for budget purposes should be quite obvious. Once the expected patient load is determined, the use of standards facilitates the determination of staff personnel requirements.

A general criticism in the field is the difficulty of obtaining upward revisions in personnel ceilings when the patient load is more than was anticipated. This was particularly true of Newport. Conversely, downward revisions of personnel should be made by the Bureau when the patient load is much less than was anticipated. The use of work load indicators and standards will enable the establishment of complements promptly and without several exchanges of correspondence and excessive delay.

#### RECOMMENDATIONS

1. Work measurement should be utilized by naval hospitals in determining and controlling their staffing requirements. The basic work load indicator for hospitals should be patient load. Personnel requirements for individual hospitals based on patient load can be predetermined with a reasonably high degree of accuracy.
2. Hospitals of the same size (patient load) should have the same size staff in the organizational units where physical layout is of minor importance. These units include personnel, finance, disbursing, laundry, transportation, and all professional services.
3. Staff requirements should be determined on an individual hospital basis for organizational units where the physical layout is significant. These units include the commissary division and such other activities in the maintenance division as shops and grounds, fire department, civilian guards, elevator operators, and janitors. The variation with patient load beyond the point where physical layout is dominant should be the same for all hospitals.
4. Staff requirements for activities such as the power plant and telephone section should do the same for all hospitals having similar equipment.
5. Work measurement should also be used by hospitals as a basis for locating overloading, spotting bottlenecks, stimulating interest in productivity, revealing sub-standard performance, and improving internal operations in general.



6. The proposed standard staff requirements listed in Table 3 should be utilized. The standards established are tentative and should not be considered as fixed. Based on present policies and procedures, most of the standards proposed herein are accurate to within ten percent. It is more important that some standard should be established and used, than the standard itself be highly accurate initially.
7. The standards should be subject to continual analysis and improvements made as necessary.
8. Personnel overhead should be reduced by improvements in physical layout and consolidation or elimination of functions, where possible.
9. Hospital architects should consider the "hub and spoke" type of design for naval hospitals in the future. The main hospital units would be located in a large hub, and the wards would comprise the spokes. Regardless of the type of design employed, however, special emphasis for future hospital construction should be placed on staffing requirements and possible expansion in the event of an emergency.
10. As hospitals decrease in size, certain necessary overhead functions, such as the fire department, telephone service, heating, laundry, etc., should be combined with those at other naval activities in the area, where possible, in order to reduce overhead costs.
11. Where feasible, hospitals should be consolidated or the patient load should be balanced for economy in operation.
12. Consideration should be given to demolishing many of the antiquated buildings no longer in use at naval hospitals in order to save maintenance personnel, eliminate excess heating costs, and reduce fire hazards.
13. Civilian and enlisted complement control should be centralized in one office in the hospital. Complete responsibility for establishing both civilian and military allowances for hospitals should be assigned to one division in the Bureau of Medicine and Surgery.
14. The Expense Analysis Register should be revised, as proposed in Exhibit 15, to include reporting on a purely organizational basis, complete workload information for each unit, and the number of civil employees and military personnel in each unit.



15. Data obtained from individual hospitals on the Expense Analysis Registers should be made available to all hospitals through the circulation of summary sheets. Hospitals can be expected to improve performance by themselves if they are given a basis for comparison.

TABLE 1

## TYPICAL WORK LOAD INDICATORS

<u>Division or Service</u>	<u>% of Total Staff</u>	<u>Work Load Indicator</u>
Finance	4	Patient Load
Disbursing	1	Accounts Handled
Personnel (and Records)	6	Patient Load
Welfare and Recreation	0 plus	None
Commissary	11	Rations Served
Maintenance	$\frac{1}{2}$	None
Laundry	$2\frac{1}{2}$	Pieces of Laundry
Transportation	2	Mileage
Power Plant	$2\frac{1}{2}$	None
Shops and Grounds	$6\frac{1}{2}$	$10 + \frac{\text{Sq. Ft.}}{25,000} + \frac{\text{Acres}}{10} + \frac{\text{Pa. Load}}{100}$
Janitors	$\frac{1}{2}$	None
Elevator	0 plus	None
Administrative (Misc.)	1	Patient Load
Nurse & Officers Quarters	1	Patient Load
Security	2	Patient Load
Civilian Guards	1	None
Fire Department	1	None
Telephone	1	None
Library	0 plus	None
Surgical (MOR)	2	Number of Operations
Medical (ECG)	0 plus	None
EENT Clinic	1	Number of visits
Urology - Cystoscopy	0 plus	None
N.P. - Cler. & EEG	$\frac{1}{2}$	None
Dependents	$7\frac{1}{2}$	Dependent in-patients
Dental	1	Number of Sitzings
X-Ray	1	Number of X-Rays
Laboratory	$1\frac{1}{2}$	Number of Examinations
Pharmacy	$\frac{1}{2}$	None
Physio-therapy	$\frac{1}{2}$	Patient Load
Occupational Therapy	0 plus	None
Wards	20	Number of Wards
Nurses	8	Number of Wards
Medical and Dental Officers	8	Patient Load
Miscellaneous	2	None



1918

NEW YORK, N.Y.

NEW YORK, N.Y.

NEW YORK, N.Y.

TABLE 3

## PROPOSED STAFF REQUIREMENTS FOR STANDARD NAVAL HOSPITALS

Administrative Divisions	%	At Patient Load							
	Mil.	200	400	600	800	1000	1200	1400	1600
Finance	35	12	16	20	22	23	24	25	26
Disbursing	10	4	5	6	7	8	9	10	11
Personnel (and Records)	35	16	26	33	40	46	51	56	61
Welfare & Recreation	100	1	2	3	3	4	4	4	5
Commissary	10	30	46	59	65	74	81	87	93
Maintenance (office)	65	3	3	4	5	6	6	7	7
Laundry	5	6	10	13	16	19	22	24	26
Transportation	0	8	9	10	12	14	15	16	17
Power Plant	0	11	11	12	12	12	12	12	12
Shops and Grounds	0	21	28	35	42	49	54	59	64
Janitors	0	-	2	3	4	5	6	7	8
Elevator Operators	0	-		(4)	(4)	(6)	(6)	(6)	(6)
Administrative (Misc.)	50	2	3	4	5	6	7	8	9
Nurse & Officers' Quarters	0	5	5	6	7	8	9	10	11
Security - MAA	100	6	9	12	15	18	21	24	27
Civilian Guards	0	(6)	6	6	9	12	12	15	15
Fire Department	0	(7)	(7)	7	10	10	10	10	13
Telephone Operators	0	(3)	(6)	6	6	6	6	6	6
Library	0	1	1	2	2	3	3	3	4
Miscellaneous	50	2	3	4	5	6	7	8	9
Total Administrative	20	128	185	245	287	329	359	391	424
		(144)	(198)	(249)	(291)	(335)	(365)	(397)	(430)
% of Total Staff	20%	49%	48%	47%	45%	44%	43%	42%	41%
<b>Professional Services</b>									
Surgical - MOR & CSS	100	6	8	11	13	16	18	19	20
Medical - E.C.G.	100	1	1	2	2	2	2	2	2
E.E.N.T. - Clinic	90	3	4	4	5	6	7	8	9
Urology - Cystoscopy	100	1	1	2	2	2	2	2	2
N.P. - Cler. & EEG	100	2	2	3	3	4	4	4	5
Dependents-incl. Nurses	75	16	28	40	51	60	67	74	80
Dental	100	2	3	4	5	6	7	8	9
X-Ray	90	3	4	5	6	7	8	9	10
Laboratory	70	5	6	8	10	12	14	16	18
Pharmacy	100	2	3	3	4	4	4	5	5
Physio-therapy	70	2	2	3	4	5	6	7	8
Occupational Therapy	50	-	1	2	2	2	2	3	3
Miscellaneous	100	3	4	5	6	7	8	9	10
Wards	100	60	80	105	135	160	185	210	235
Nurses-excl. Dependents	100	27	34	43	56	69	82	94	105
Med. & Dent. Officers	100	18	30	40	50	60	70	80	90
Total Clinical Staff	95	151	211	280	354	428	486	550	611
Total Corpsmen		117	163	214	266	320	357	401	443
Total Nurses		35	46	59	76	93	109	124	137
Total Med. & Dent. Officers		18	30	40	50	60	70	80	90
Total Civilians		109	147	212	249	284	309	336	365
Total Staff		279	396	525	641	757	845	941	1,035
Staff Per Patient Ratio		1.40	.99	.88	.80	0.75	0.71	0.67	0.65



TABLE 4

## PROPOSED STAFF REQUIREMENTS FOR PORTSMOUTH

(in comparison with staff requirements for standard hospital on Table 3 )

<u>Units Where Staff Differs from Standard</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Commissary	60	75	90	100	110	115	120	125
Shops and Grounds	44	48	52	56	60	64	68	72
Elevator Operators	2	2	2	2	2	2	2	2
Civilian Guards	6	9	12	12	12	12	15	15
Subtotal	112	134	156	170	184	193	205	214
All other units	241	327	422	521	617	692	773	855
Total Staff	353	461	578	691	801	885	978	1069
"Standard Staff	279	396	525	641	757	845	941	1035
Staff/Patient Ratio	1.76	1.15	0.196	0.86	0.80	0.74	0.70	0.67
"Standard" Staff/Patient Ratio	1.40	0.99	0.88	0.80	0.75	0.71	0.67	0.65

TABLE 5

## PROPOSED STAFF REQUIREMENTS FOR PHILADELPHIA

(in comparison with staff requirements for standard hospital on Table 3)

<u>Units Where Staff Differs from Standard</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Commissary	50	60	70	80	90	95	100	105
Food Carts				20	25	30	35	40
Shops and Grounds	35	38	41	47	50	53	57	61
Janitors	6	7	8	8	9	9	10	10
Elevator Operators	6	7	8	8	8	8	8	8
Fire Department	0	0	0	4	4	4	4	4
Subtotal	97	112	127	167	186	199	214	228
All other units	237	326	421	520	619	694	778	857
Total Staff	334	438	548	687	805	893	992	1085
"Standard" Staff	279	396	525	641	757	845	941	1035
Staff/Patient Ratio	1.67	1.09	0.91	0.86	0.80	0.74	0.71	0.68
"Standard" Staff/Patient Ratio	1.40	0.99	0.88	0.80	0.75	0.71	0.67	0.65



TABLE 6

## PROPOSED STAFF REQUIREMENTS FOR GREAT LAKES

(in comparison with staff requirements for standard hospital on Table 3 )

<u>Units Where Staff Differs from Standard</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Commissary	50	60	70	80	90	95	100	105
Shops and Grounds	36	40	44	48	52	56	60	64
Janitors	1	1	1	2	2	2	2	2
Fire Department	0	0	0	0	0	0	0	0
Telephone Section	1	2	3	3	3	4	4	4
Power Plant	14	14	15	15	15	15	15	15
Subtotal	102	117	133	148	162	172	181	190
All other units	217	303	397	493	589	664	745	825
Total Staff	319	420	530	641	751	863	926	1015
"Standard" Staff	279	396	525	641	757	845	941	1035
Staff/Patient Ratio	1.60	1.05	0.88	0.80	0.75	0.70	0.66	0.64
"Standard" Staff/Patient Ratio	1.40	0.99	0.88	0.80	0.75	0.71	0.67	0.65

TABLE 7

## PROPOSED STAFF REQUIREMENTS FOR SAN DIEGO

(in comparison with staff requirements for standard hospital on Table 3 )

<u>Units Where Staff Differs from Standard</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Commissary	60	70	90	120	130	140	150	155
Shops and Grounds	44	47	50	53	56	59	63	67
Janitors	2	3	4	5	6	7	8	9
Fire Department	0	7	7	7	10	10	10	13
Civilian Guards	6	9	12	12	15	15	15	15
Subtotal	112	136	163	197	217	231	246	259
All other units	231	320	415	511	607	683	763	843
Total Staff	343	456	578	708	824	913	1009	1102
"Standard" Staff	279	396	525	641	757	845	941	1035
Staff/Patient Ratio	1.72	1.14	0.96	0.88	0.82	0.76	0.72	0.69
"Standard" Staff/Patient Ratio	1.40	0.99	0.88	0.80	0.75	0.71	0.67	0.65



TABLE 8

## PROPOSED STAFF REQUIREMENTS FOR NEWPORT

(in comparison with staff requirements for standard hospital on Table 3)

<u>Units Where Staff Differs from Standard</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Commissary	45	55	65	75	80	85	90	95
Shops and Grounds	29	32	35	38	41	44	47	50
Janitors	1	2	2	2	2	2	2	2
Civilian Guards	5	6	6	9	9	9	9	9
Fire Department	0	0	0	0	0	0	0	0
Telephone Section	0	0	0	0	0	0	0	0
Subtotal	80	95	108	124	132	140	148	156
All other units	228	314	409	505	601	676	757	836
Total Staff	308	409	517	629	733	816	905	992
"Standard" Staff	279	396	525	641	757	845	941	1035
Staff/Patient Ratio	1.54	1.04	0.86	0.78	0.73	0.68	0.65	0.62
"Standard" Staff/Patient Ratio	1.40	0.99	0.88	0.80	0.75	0.71	0.67	0.65

TABLE 9

## TOTAL STAFF PER PATIENT RATIO - PAST PERFORMANCE

Date	<u>PORTSMOUTH</u>			<u>PHILADELPHIA</u>			<u>GREAT LAKES</u>			<u>SAN DIEGO</u>			<u>NEWPORT</u>		
	Pat- ients	Staff	Per Patient	Pat- ients	Staff	Per Patient	Pat- ients	Staff	Per Patient	Pat- ients	Staff	Per Patient	Pat- ients	Staff	Per Patient
<u>1946</u>															
Jan	1181	1320	1.12	3042	2030	0.67	7400	3380	0.46	4252	3550	0.83	1198	802	0.67
Feb	1201	1190	.99	2725	2180	.80	6130	3410	.56	3932	3250	.83	1117	747	.67
Mar	1073	1110	1.03	2595	2170	.82	4940	3190	.65	3482	2940	.84	1065	750	.70
Apr	1006	1060	1.05	2456	1980	.81	4350	2600	.60	3025	2740	.91	883	771	.87
May	931	1000	1.07	2287	1900	.83	3850	2300	.60	2396	2550	1.06	734	700	.95
Jun	885	830	.94	2015	1910	.95	3220	2020	.63	1930	2310	1.20	635	577	.91
Jul	865	760	.88	1856	1810	.98	2740	1690	.62	1754	1900	1.08	602	533	.86
Aug	620	670	1.08	1560	1620	1.04	2110	1620	.77	1684	1730	1.03	558	464	.83
Sep	586	640	1.09	1463	1410	.96	1620	1430	.88	1573	1530	.97	607	446	.74
Oct	534	630	1.18	1383	1310	.95	1260	1320	1.05	1552	1250	.81	606	437	.72
Nov	461	610	1.32	1308	1180	.91	1180	1000	.85	1415	1170	.83	561	413	.74
Dec				1220	1110	.91	1020	860	.84	1351	1140	.84	505	388	.77
<u>1947</u>															
Jan				1215	1040	.86	940	780	.83	1415	1120	.79	548	413	.75
Feb				1230	1000	.81	880	780	.89	1381	1080	.78	632	413	.65
Mar							750	750	1.00				637	412	.65
Apr													658	416	.63



TABLE 10  
MEDICAL AND DENTAL OFFICERS PER PATIENT

	<u>Philadelphia</u>		<u>Newport</u>		<u>San Diego</u>		<u>Great Lakes</u>	
<u>Date</u>	<u>M.O. &amp; D.O.</u>	<u>Patients per Officer</u>	<u>M.O. &amp; D.O.</u>	<u>Patients per Officer</u>	<u>M.O. &amp; D.O.</u>	<u>Patients per Officer</u>	<u>M.O. &amp; D.O.</u>	<u>Patients per Officer</u>
Jan	127	24.0	62	19.3	183	23.2	260	28.4
Feb	135	20.2	55	20.3	195	20.1	265	23.1
Mar	141	18.4	57	18.7	196	17.8	265	18.6
Apr	146	16.8	70	12.6	177	17.1	240	18.1
May	179	14.0	49	15.0	202	11.8	255	15.1
June	166	12.1	56	11.3	173	11.1	235	13.7
July	161	11.5	45	13.4	155	11.3	175	15.6
Aug	128	12.2	35	15.9	116	14.5	135	15.6
Sept	117	12.5	36	16.8	105	15.0	120	13.5
Oct	113	12.2	38	15.5	98	15.8	130	9.7
Nov	79	16.6	40	14.0	95	14.9	115	10.3
Dec	77	15.8	39	12.9	90	15.0	110	9.3
<u>1947</u>								
Jan	75	16.2	38	14.4	85	16.7	90	10.4
Feb	75	16.4	39	16.2	80	17.3	80	11.0
Mar			32	19.9	80	17.0		
Apr			34	19.3				

TABLE 11

EXCESS STAFF IN FIVE NAVAL HOSPITALS  
COMPARED WITH PROPOSED STANDARD STAFF REQUIREMENTS

	Portsmouth 450 Patients	Phila. 1200 Patients	Gr. Lakes 800 Patients	San Diego 1350 Patients	Newport 650 Patients	Total Excess Staff	Annual Payroll Sav- ings (Est.)
Finance	5	4	15	20	2	46	\$ 115,000
Disbursing	1	2	5	7	0	15	38,000
Personnel	4	-4	23	22	0	45	112,000
Commissary	30	104	20	45	-1	198	396,000
"Ideal" *	(79)	(118)	(35)	(112)	(-1)	(345)	(690,000)
Laundry	2	14	2	7	-2	23	46,000
Transportation	8	10	7	9	-8	26	52,000
Power Plant	2	-1	5	4	-2	8	20,000
Shops & Grounds	10	10	4	25	-12	37	92,000
Janitors	-1	3	-3	6	-1	4	7,000
Quarters	0	-1	4	5	-2	6	5,000
Security	0	-5	7	-5	-6	-9	-20,000
Civilian Guards	4	0	-	10	-1	13	30,000
Fire Dept.	3	-	10	2	-	15	38,000
Tel. Operators	<u>5</u>	<u>-</u>	<u>-</u>	<u>9</u>	<u>-</u>	<u>14</u>	<u>35,000</u>
	73	138	99	166	-33	441	976,000
	(112)*	(152)	(114)	(233)			(1,270,000)
M.O.R.	1	10	3	-1	-2	10	\$ 20,000
E.E.N.T.	0	2	2	-3	-2	-1	-2,000
Dependents	5	-16	-7	-3	0	-21	-42,000
Dental	2	6	2	0	3	13	26,000
X-Ray	2	3	6	2	0	13	26,000
Laboratory	0	8	1	-6	1	4	8,000
Pharmacy	0	2	0	0	0	2	4,000
Physio-Therapy	0	5	4	-1	0	8	16,000
Wards	-14	-25	-9	-73	-25	-146	-292,000
Nurses	-6	-18	6	-40	-20	-78	-270,000
	<u>-10</u>	<u>-24</u>	<u>8</u>	<u>-125</u>	<u>-45</u>	<u>-196</u>	<u>-506,000</u>

\* Commissary "ideal" staff savings are based on changes in physical layout.

Net Savings

470,000  
(764,000)



TABLE 12

PERCENTAGE DISTRIBUTION OF TOTAL STAFF IN FIVE HOSPITALS  
CLINICAL SERVICES AND ADMINISTRATIVE DIVISIONS

Date	CLINICAL SERVICES					ADMINISTRATIVE DIVISIONS				
	Ports. %	Phila. %	Gr. L. %	S.D. %	Newp. %	Ports. %	Phila. %	Gr. L. %	S.D. %	Newp. %
<u>1946</u>										
Jan	49	57	56	60	48	51	43	44	40	52
Feb	46	59	57	60	46	54	41	43	40	54
Mar	45	59	58	56	46	55	41	44	44	54
Apr	45	58	56	53	45	55	41	44	47	55
May	44	56	55	46	42	55	44	45	54	58
June	43	56	56	46	42	57	44	44	54	58
July	42	56	53	48	41	58	45	47	52	59
Aug	41	55	51	44	39	59	45	48	56	61
Sept	39	54	50	43	39	61	46	50	57	61
Oct	39	53	52	40	41	61	47	48	60	59
Nov	39	52	52	39	42	61	48	48	61	58
Dec		52	52	40	43		48	48	61	57
<u>1947</u>										
Jan		50	48	41	49		50	52	59	51
Feb		50	46	41	49		50	54	59	51
Mar				41	48				59	52
Apr					48					52
Average of last month										
		44.8%					55.2%			

TABLE 13

## PERCENTAGE DISTRIBUTION OF CORPSMEN IN FIVE HOSPITALS

Date	% WARDS					% CLINICAL SERVICES					% ADMINISTRATIVE SERVICES				
	Ports.	Phila.	Gr.L.	S.D.	Newp.	Ports.	Phila.	Gr.L.	S.D.	Newp.	Ports.	Phila.	Gr.L.	S.D.	Newp.
<u>1946</u>															
Jan	29	34	48	68	43	28	34	14	18	17	48	32	38	14	40
Feb	33	37	49	72	42	21	34	14	18	20	46	29	37	10	38
Mar	36	38	48	68	39	22	38	14	18	21	42	24	38	14	40
Apr	40	38	48	66	37	21	39	14	18	22	39	23	38	15	41
May	44	36	43	48	37	19	39	16	23	20	39	24	41	29	43
Jun	40	35	40	52	37	20	40	19	22	23	40	25	41	26	40
Jul	38	43	41	56	39	23	34	17	21	25	39	23	42	23	36
Aug	41	43	38	52	38	21	34	19	22	23	38	23	43	26	39
Sep	40	44	38	53	36	19	35	18	24	22	41	22	44	23	42
Oct	41	40	42	36	38	19	35	17	33	23	40	25	40	31	39
Nov	44	42	42	35	39	19	37	18	32	24	37	23	40	33	37
Dec		43	40	37	40			24	30	20		20	36	33	40
<u>1947</u>															
Jan		39	31	35	53		41	21	32	17		20	40	33	30
Feb		40	36	35	46		40	21	32	25		20	43	33	29
Mar				34	42				32	27				33	31
Apr					41					27					32
Last 3															
Mo.Avg.	41.7	40.7	38.3	34.7	43.0	19	39.3	22	32	26.3	39.3	20	39.7	33	30.7
Average			39.3%					27.5%					32.5%		



TABLE 14

## COMPARISON OF PROPOSED STANDARD STAFF REQUIREMENTS WITH AVERAGE PAST PERFORMANCE

% OF TOTAL STAFF IN ADMINISTRATIVE DIVISIONS

<u>Patient Load</u>	<u>Past Performance</u>	<u>Proposed</u>
200	(65)	49
400	60	48
600	57	47
800	56	45
1000	55	44
1200	54	43
1400	52	42
1600	50	41

PERCENT DISTRIBUTION OF CORPSMEN

	<u>Past Performance</u>	<u>Proposed</u>
Administrative Divisions	33%	20%
Wards	39%	50%
Other Clinical Services	27%	30%
	<u>100%</u>	<u>100%</u>

PATIENTS PER NURSE

<u>Patient Load</u>	<u>Past. Perform.</u>	<u>Proposed</u>
200		6
400	14	9
600	16	10
800	17	11
1000	18	11
1200	18	11
1400	19	11
1600		11

PATIENT PER WARD CORPSMEN

<u>Past Perform.</u>	<u>Proposed</u>
	3½
6	5
7	6
8	6
8	6
8	6
9	7
	7

# STAFFING CURVES

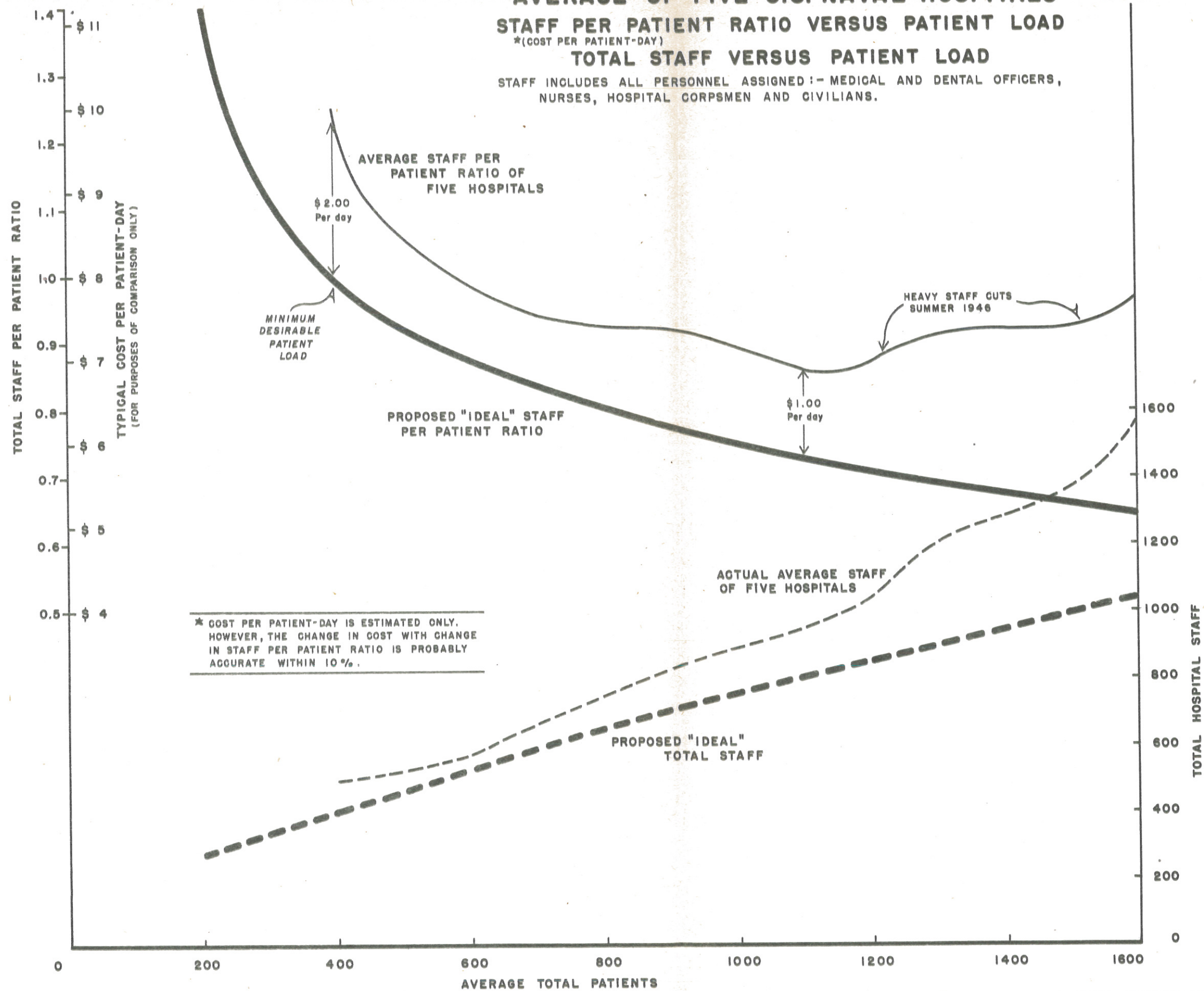
## AVERAGE OF FIVE U.S. NAVAL HOSPITALS

### STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

\*(COST PER PATIENT-DAY)

### TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS, NURSES, HOSPITAL CORPSMEN AND CIVILIANS.





RECEIVED  
JAN 10 1944  
NAVY DEPARTMENT  
WASHINGTON, D. C.

# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, PORTSMOUTH, VA.

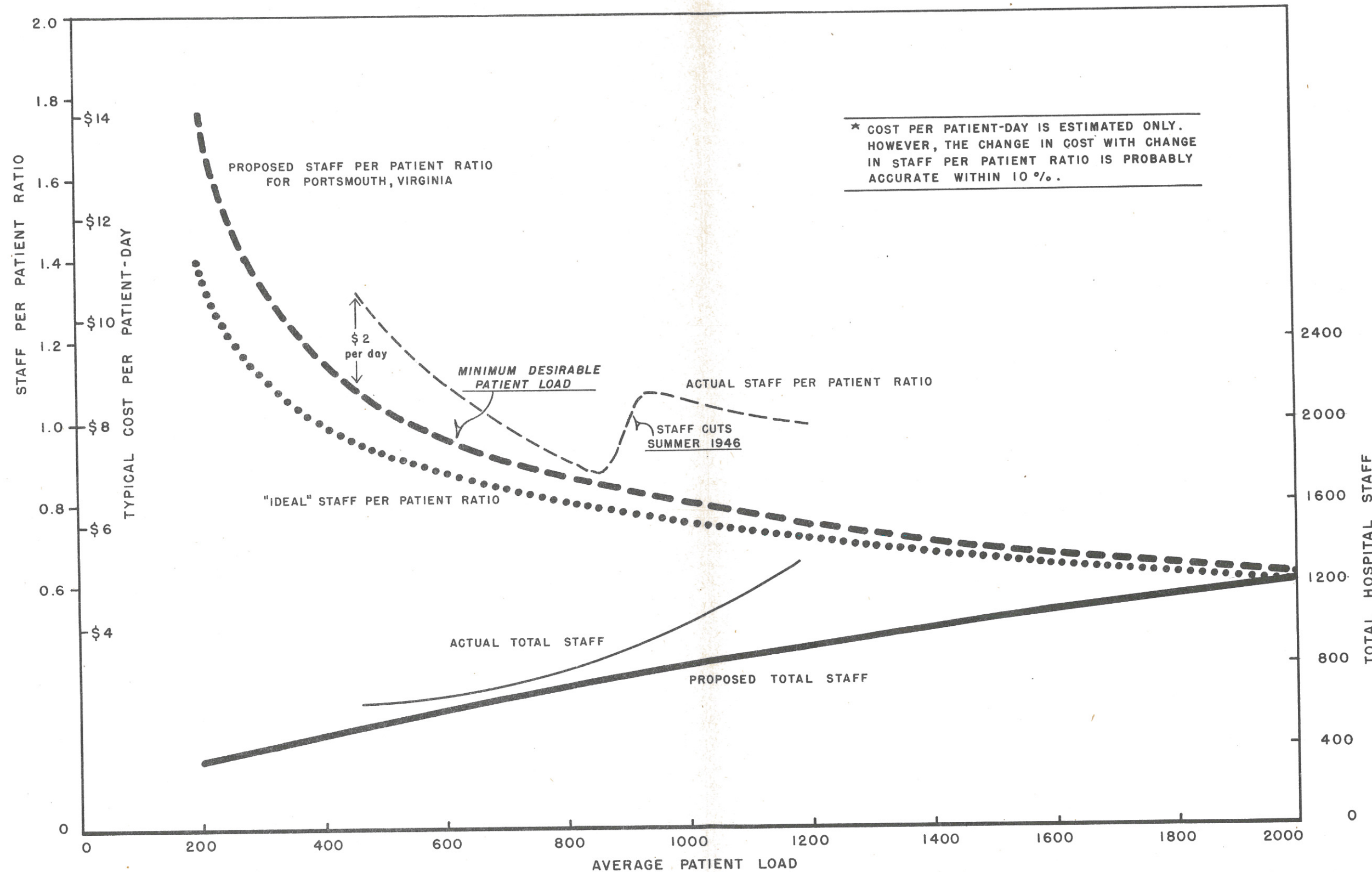
EXHIBIT 7

## STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

★ (COST PER PATIENT-DAY)

## TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS,  
NURSES, HOSPITAL CORPSMEN AND CIVILIANS.





STARTING CURVE FOR U.S. NAVAL HOSPITAL, PONTSMOUTH, VA

STAFF FOR PATIENTS AND VISITORS

TOTAL STAFF VERSUS PATIENT LOAD

STAFF FOR PATIENTS AND VISITORS  
TOTAL STAFF VERSUS PATIENT LOAD

STAFF FOR PATIENTS AND VISITORS  
TOTAL STAFF VERSUS PATIENT LOAD

STAFF FOR PATIENTS AND VISITORS  
TOTAL STAFF VERSUS PATIENT LOAD

STAFF FOR PATIENTS AND VISITORS  
TOTAL STAFF VERSUS PATIENT LOAD

# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, PHILADELPHIA

EXHIBIT 8

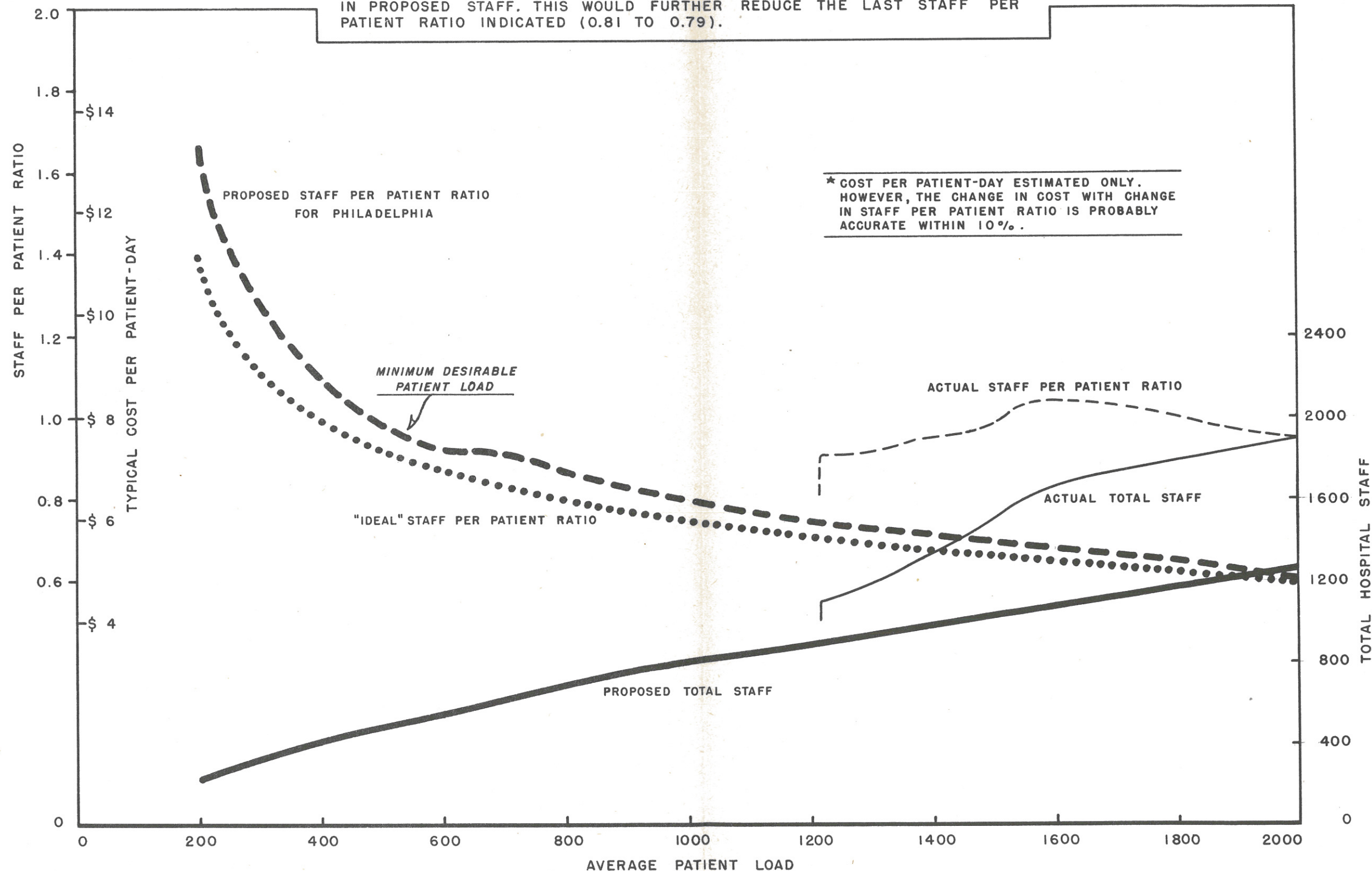
## STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

★ (COST PER PATIENT-DAY)

## TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS, NURSES, HOSPITAL CORPSMEN AND CIVILIANS.

ACTUAL STAFF FURTHER INCLUDES ABOUT 30 PERSONNEL FOR AURAL RE-HABILITATION AND VETERAN OUTPATIENT CLINIC, WHICH IS NOT REFLECTED IN PROPOSED STAFF. THIS WOULD FURTHER REDUCE THE LAST STAFF PER PATIENT RATIO INDICATED (0.81 TO 0.79).



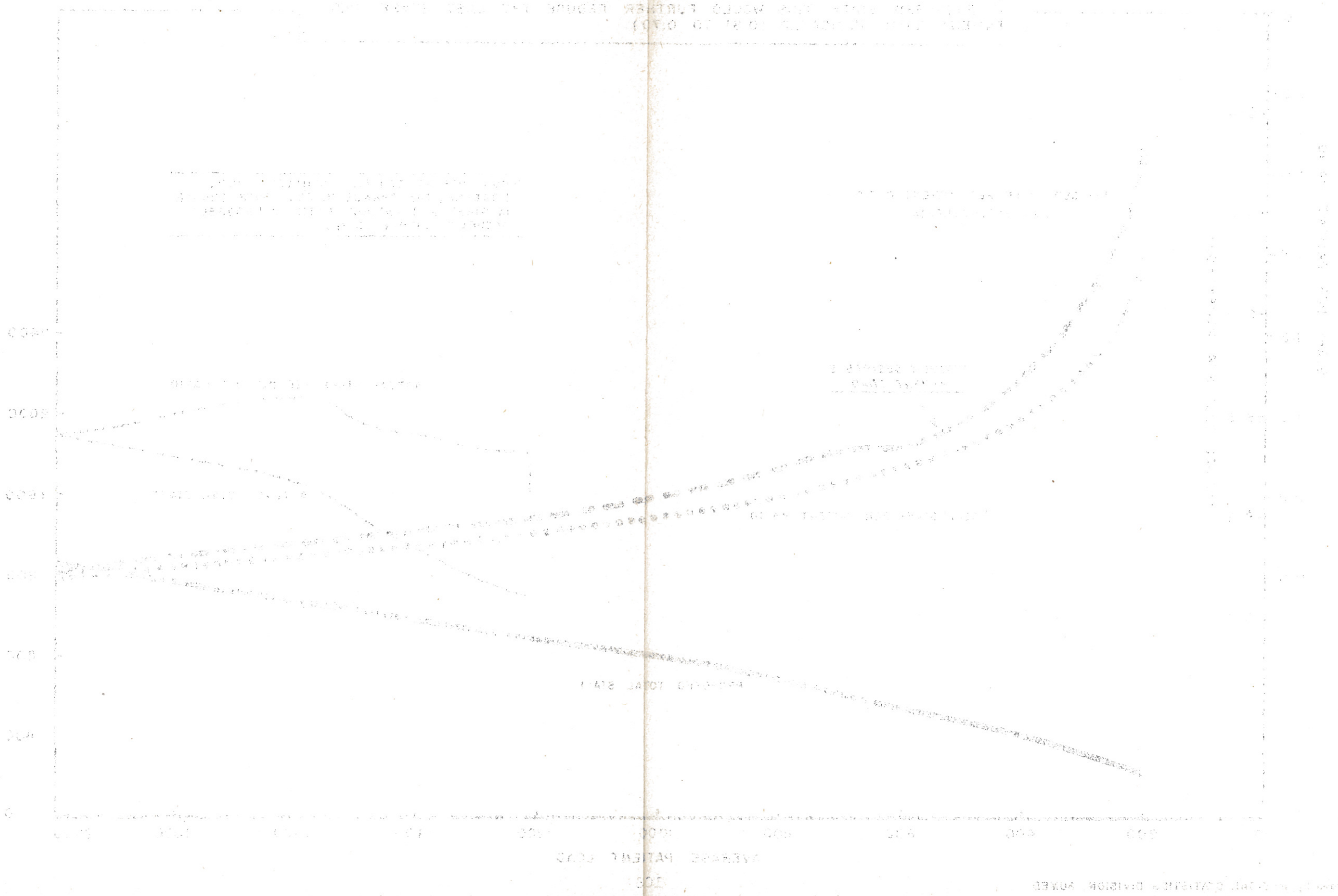


# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, PHILADELPHIA

STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

TOTAL STAFF VERSUS PATIENT LOAD

THE FOLLOWING TABLES ARE PRESENTED FOR THE INFORMATION OF THE COMMANDING OFFICER AND THE STAFF. THE TABLES SHOW THE STAFF PER PATIENT RATIO AND THE TOTAL STAFF REQUIRED FOR THE HOSPITAL AT VARIOUS PATIENT LOADS. THE STAFF PER PATIENT RATIO IS BASED ON THE ASSUMPTION THAT THE HOSPITAL IS OPERATING AT 100% CAPACITY. THE TOTAL STAFF REQUIRED IS BASED ON THE ASSUMPTION THAT THE HOSPITAL IS OPERATING AT 100% CAPACITY.



# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, GREAT LAKES

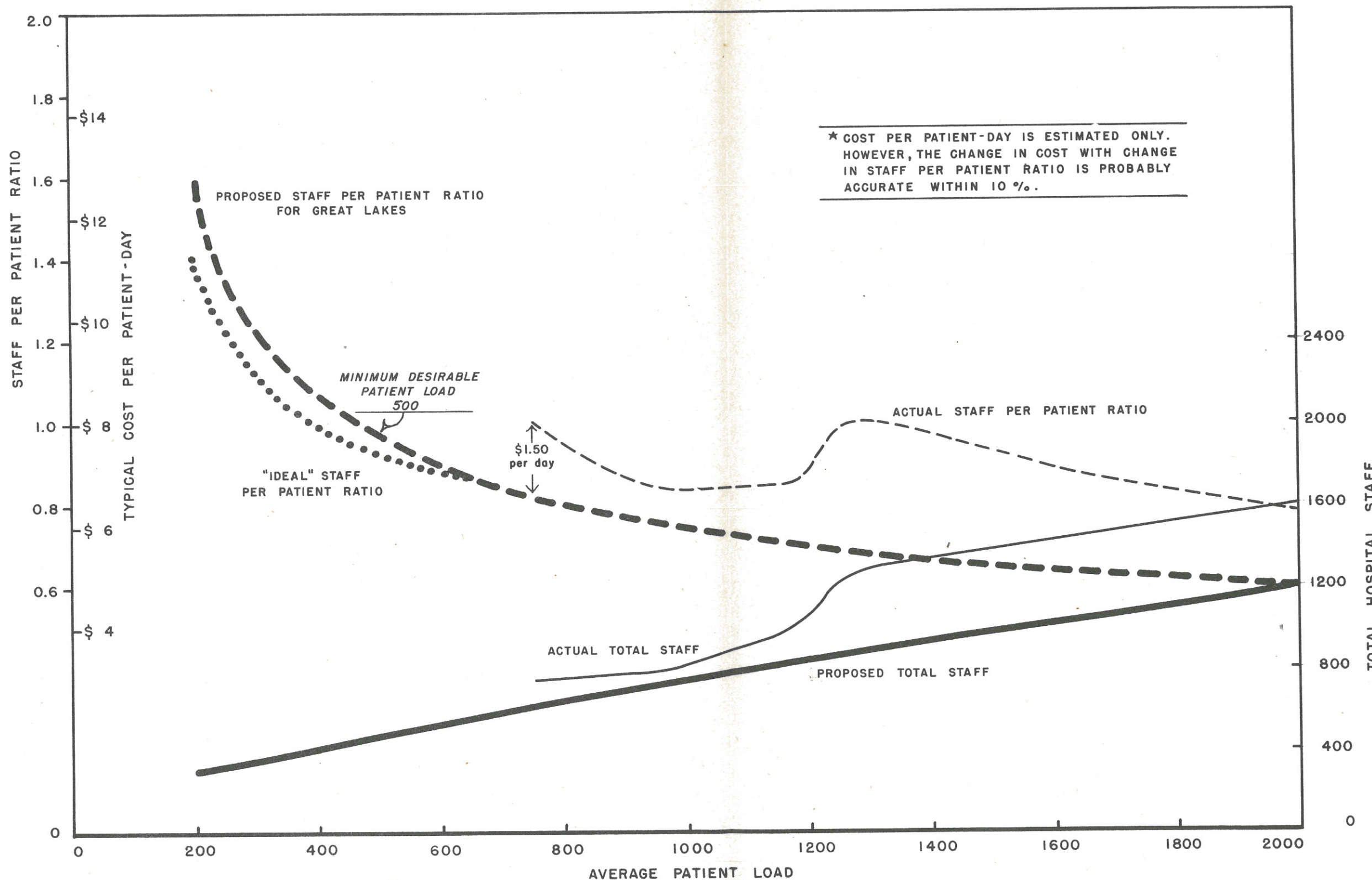
EXHIBIT 9

## STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

★(COST PER PATIENT-DAY)

## TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS,  
NURSES, HOSPITAL CORPSMEN AND CIVILIANS.

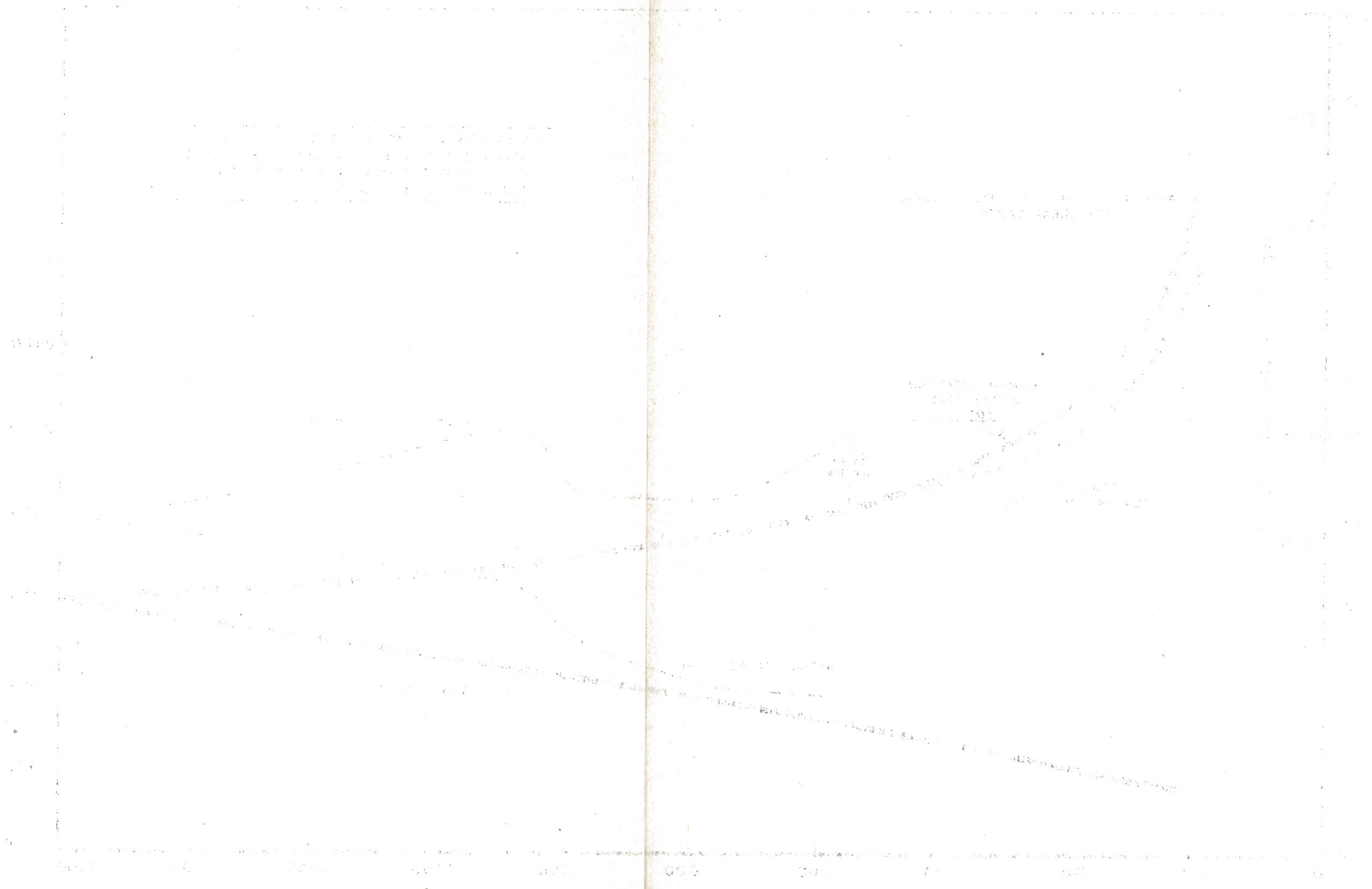




# STARTING CURVE FOR U.S. NAVAL HOSPITAL GREAT LAKES

STATE PER PATIENT RATIO  
TOTAL STAFF VERSUS PATIENT RATIO

STAFF PER PATIENT RATIO  
TOTAL STAFF VERSUS PATIENT RATIO



STAFF PER PATIENT RATIO

# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, SAN DIEGO

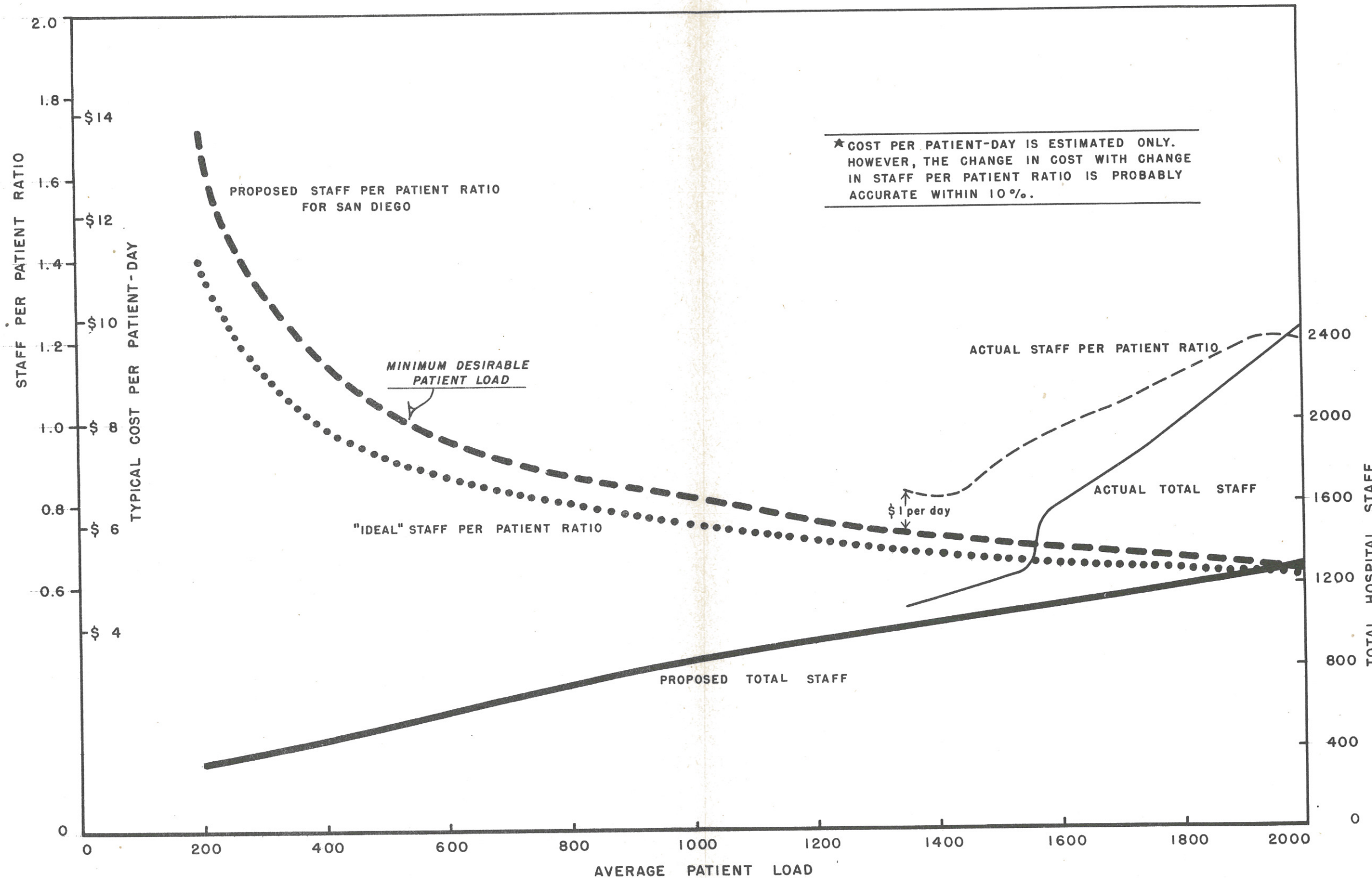
EXHIBIT 10

## STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

\*(COST PER PATIENT-DAY)

## TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS,  
NURSES, HOSPITAL CORPSMEN AND CIVILIANS.





# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, SAN DIEGO

STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

TOTAL STAFF VERSUS PATIENT LOAD

ASSIGNED - MEDICAL AND DENTAL STAFF  
ASSIGNED - GENERAL SUPPORT AND SERVICE STAFF

STAFF PER PATIENT RATIO  
TOTAL STAFF  
ASSIGNED - MEDICAL AND DENTAL STAFF  
ASSIGNED - GENERAL SUPPORT AND SERVICE STAFF

STAFF PER PATIENT RATIO  
TOTAL STAFF  
ASSIGNED - MEDICAL AND DENTAL STAFF  
ASSIGNED - GENERAL SUPPORT AND SERVICE STAFF



STAFF PER PATIENT RATIO

STAFF PER PATIENT RATIO

# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, NEWPORT

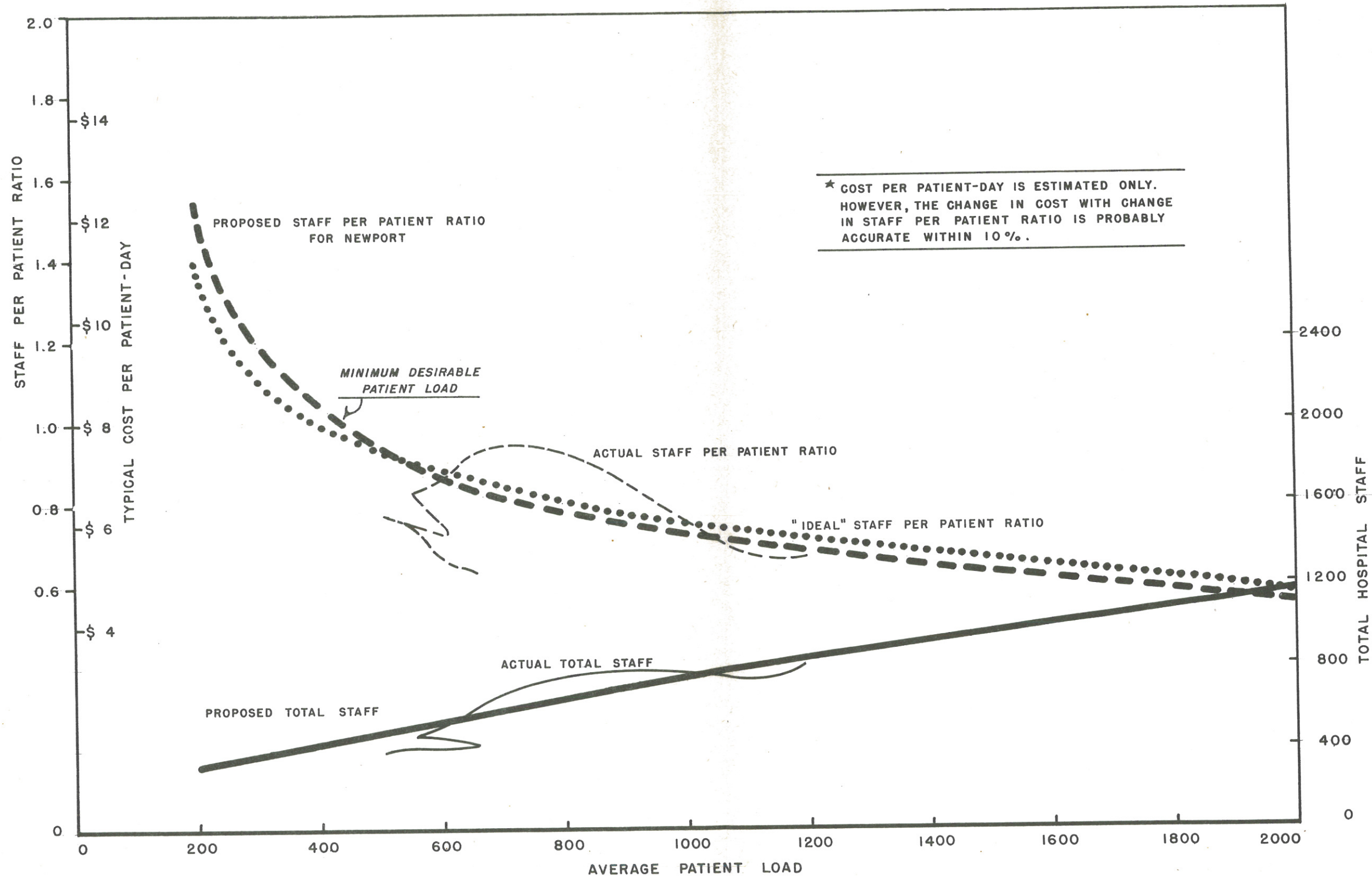
EXHIBIT II

## STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

\*(COST PER PATIENT-DAY)

## TOTAL STAFF VERSUS PATIENT LOAD

STAFF INCLUDES ALL PERSONNEL ASSIGNED:- MEDICAL AND DENTAL OFFICERS, NURSES, HOSPITAL CORPSMEN AND CIVILIANS.



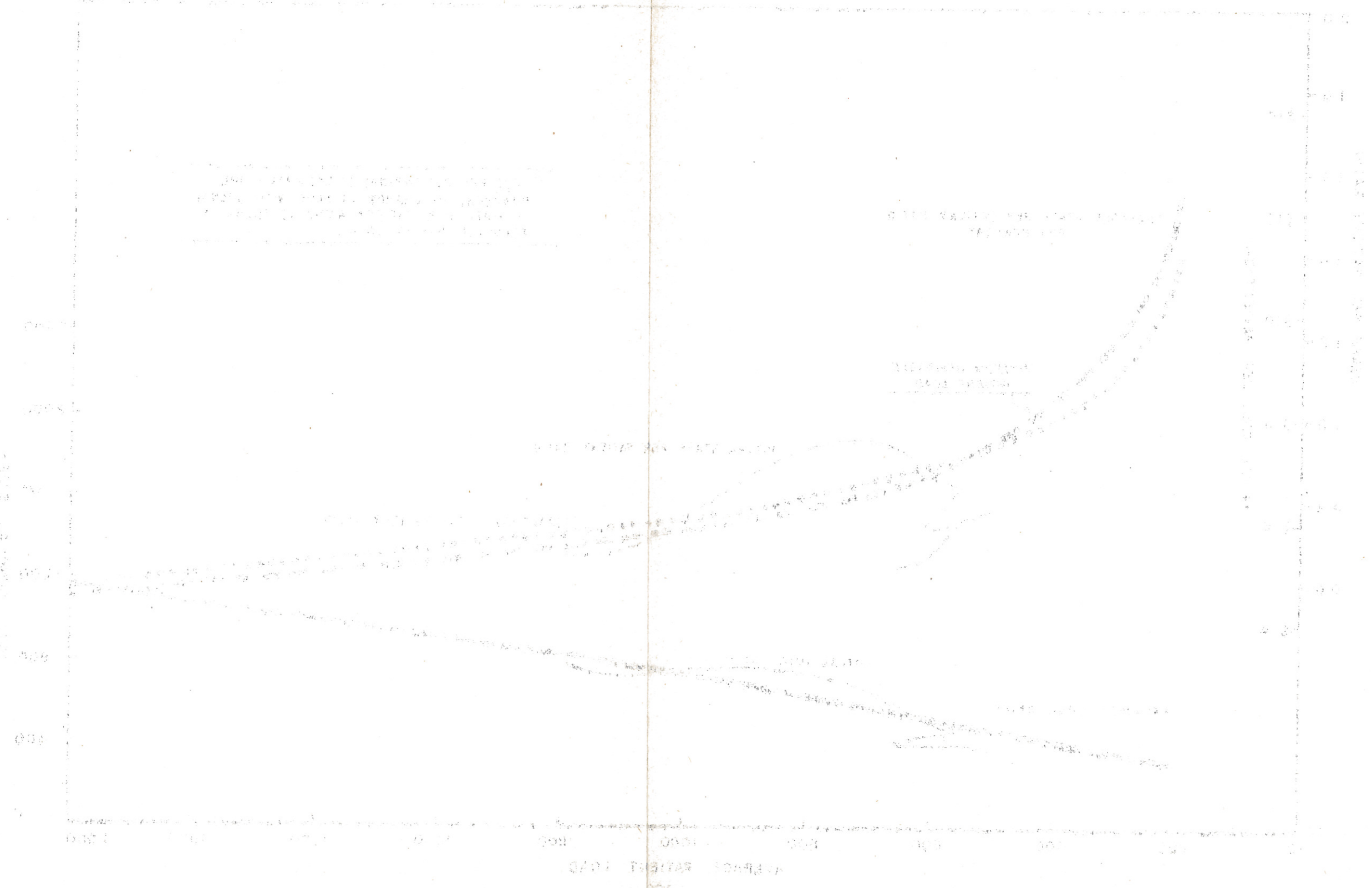


# STAFFING CURVE FOR U.S. NAVAL HOSPITAL, NEWPORT

STAFF PER PATIENT RATIO VERSUS PATIENT LOAD

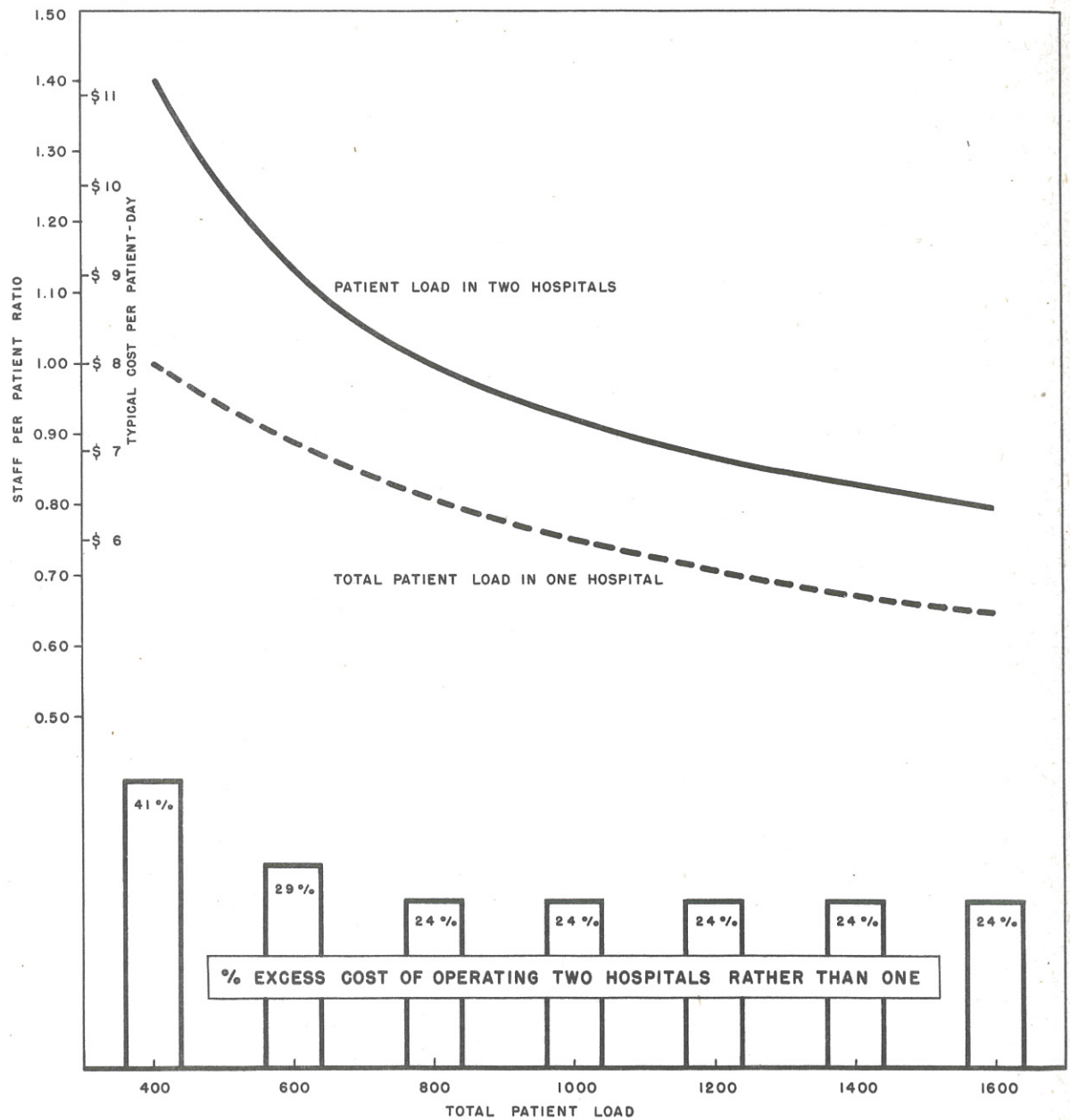
TOTAL STAFF VERSUS PATIENT LOAD

DATA SOURCES: ALL REPORTS SUBMITTED TO THE HOSPITAL COMMANDANT, NEWPORT, RHODE ISLAND, 1954-1955



# COMPARISON OF COSTS IN OPERATING TWO HOSPITALS VERSUS ONE HOSPITAL AT SAME TOTAL PATIENT LOAD

EXHIBIT 13



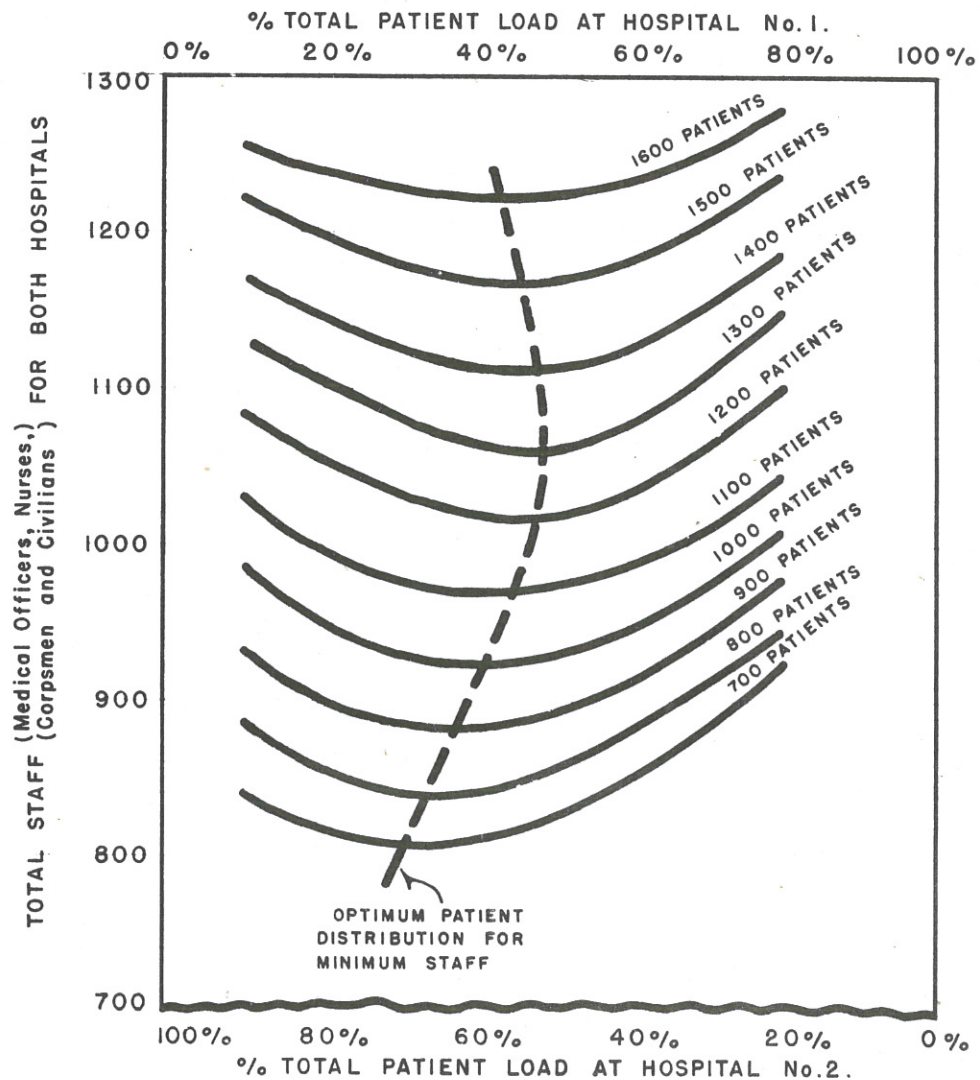
NOTE: CURVES ABOVE BASED ON "IDEAL" EFFICIENT HOSPITALS WITH EXTREMELY LOW OVERHEAD. IN PRACTICE, THE DIFFERENCE IN COST OF OPERATING TWO NAVAL HOSPITALS RATHER THAN ONE WOULD BE CONSIDERABLY GREATER THAN AS INDICATED ABOVE.

Drawn by  
MEDICAL STATISTICS DIVISION, BUMED





# **SAMPLE RECOMMENDED DISTRIBUTION OF TOTAL PATIENT LOAD BETWEEN TWO HOSPITALS OF DIFFERENT OVERHEAD FOR MINIMUM STAFF REQUIREMENTS**



Drawn by  
MEDICAL STATISTICS DIVISION, BUMED





## EXHIBIT 15

## SUGGESTED MODIFICATION OF EXPENSE ANALYSIS REGISTER

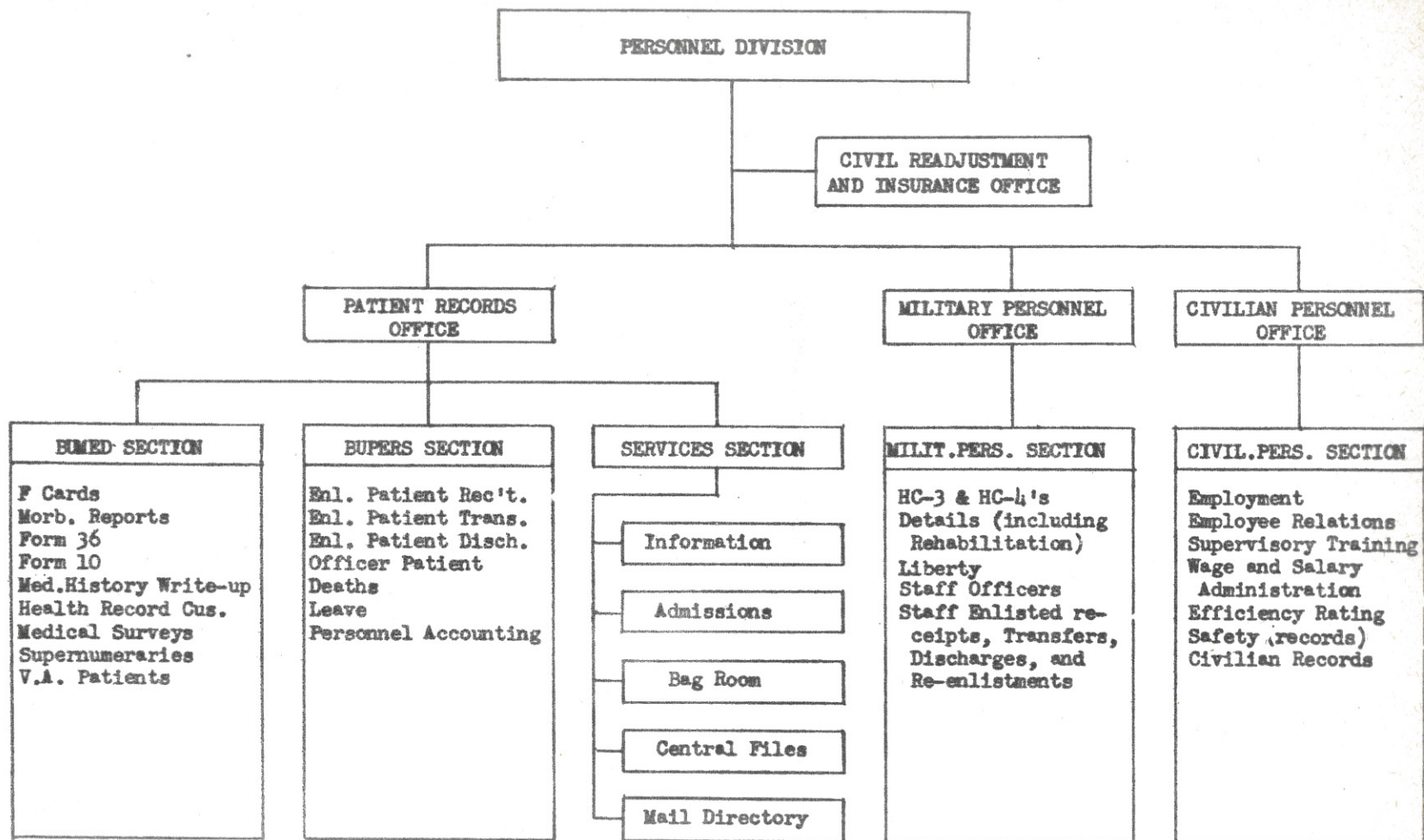
<u>Account Name</u>	<u>Work Load</u>	<u>CIVIL PERSONNEL</u>		<u>MILITARY STAFF</u>	
		<u>Number</u> <u>Employees</u>	<u>Pay</u>	<u>Number</u> <u>Employees</u>	<u>Pay</u>
Finance	800 Patients	15	9,200	7	4,500
Personnel	800 Patients	26	15,400	14	9,000
Welfare & Recreation				3	2,000
Commissary	110,000 Rations	60	30,000	5	3,500
Laundry	300,000 Pieces	15	8,000	1	800
Transportation	18,000 Miles	12	7,500		
Power Plant		12	11,000		
Shops and Grounds	400,000 Sq. Ft.	44	25,000	3	2,300
Janitors		4	1,900		
Admin. (Misc)	800 Patients	2	1,100	8	7,000
Security	800 Patients	12	6,000	15	10,000
Fire Department		9	4,500		
Telephone		6	3,000		
Library		2	1,200		
Surgical	530 Operations			14	8,900
Medical		1		3	2,500
EENT Clinic	2,700 Visits	1	600	6	5,000
Urology				3	2,000
N.P.				4	2,400
Dependents	55 In-Patients	12	5,500	52	48,000
Dental	2,400 Visits			8	5,600
X-Ray	3,200 Exams.	1	600	3	5,600
Laboratory	26,000 Exams.	2	1,500	10	7,000
Pharmacy				4	2,500
Physiotherapy		1	800	3	2,000
Occ. Therapy		1	800	1	700
Miscel. Clinical				7	4,500
Wards	800 Patients			225	154,000
		<u>238</u>	<u>133,000</u>	<u>404</u>	<u>289,800</u>





V ADMINISTRATIVE DIVISIONS





Proposed Organization Chart  
(subject to local variations)

PERSONNEL DIVISION  
Naval Hospital Survey, 1947

## THE PERSONNEL AND RECORDS DIVISIONS

### ORGANIZATION

The personnel division and records division are identified as two separate activities on the hospital organization chart in the Manual of the Medical Department. The officer in charge of each of these divisions is responsible to the administrative officer.

The authorized functions of the personnel division include: (a) the coordination of employment and assignment of civilian and enlisted personnel, (b) the custody of and responsibility for the security of all civilian and enlisted staff personnel records, (c) the current maintenance of personnel records, and (d) the preparation of prescribed personnel reports and returns.

The functions of the records division include: (a) the custody and security of all patient records, (b) the current maintenance of patients' records, (c) the preparation of prescribed reports and returns concerning patients, and (d) all correspondence pertaining to these subjects.

There are many operating variations from the directives outlined in the Manual, probably due to the lack of an accompanying explanation of hospital operation and management. The personnel division, in practice, does not assume the responsibility for an efficient hospital personnel program, but is concerned chiefly with enlisted personnel records, reports and assignments. There is a distinct lack of coordination between the assignment of enlisted and civilian personnel, and, in one instance, responsibility for civilian personnel is under the cognizance of the administrative officer. The functions of the personnel division must be clearly defined and operating relationships with the records division clarified. Arrangements should be made for close coordination of all related activities. This problem and others related thereto are more fully discussed under the section of this report devoted to "Civilian Personnel".

Consolidation of the Personnel and Records Division: A study of the detailed operations of the personnel division and the records division revealed that much duplication of effort and constant liaison could be avoided by the consolidation of these divisions. For instance, in the preparation of daily personnel reports to the Bureau of Naval Personnel, the present organizational structure necessitates the separate preparation of these reports by the personnel and records divisions. By consolidating the two offices, one section can prepare the reports for both staff and patient personnel.



The assignment and supervision of civilian personnel is officially under the cognizance of the personnel division, but most of the hospitals still include these functions under the finance division. This arrangement does not result in the close coordination essential between the assignment of civilian and enlisted personnel to positions in the hospital establishment. The management of both civilian and enlisted personnel would be most successful under the cognizance of the personnel division as now prescribed by the Manual.

Coordination is also lacking between the assignment of enlisted staff personnel and enlisted patient personnel to various work details. Patient personnel are generally assigned by the provost marshal (security officer) or chief master-at-arms, with no attempt to adjust assignments with the enlisted staff detail desk in the personnel division. More efficient utilization of patient personnel could be effected if patients were detailed to work assignments in conjunction with staff enlisted details.

Staff officer records in two hospitals are maintained in the office of the administrative officer. The daily memoranda received from this office in the form of census data and statistics are coordinated in the personnel division. Since there is no reason for maintaining staff officer records in the administrative officer's office, other than for convenience and security, it is advisable to include the responsibility for staff officer records and reports as an additional function of the personnel division. One of the largest naval hospitals is operating efficiently under this organization plan. Exhibit 16 is a proposed organization chart for the personnel division.

#### PERSONNEL

Hospital personnel are processing the current work load adequately, but weaknesses in the organization are affecting maximum efficiency. The concentration of too much authority in division officers affects the performance of subordinate personnel adversely. Personnel officers and records officers fail to delegate authority to responsible group supervisors. This resolves itself in the indispensable person, and in too many subordinates reporting to the personnel or records officer. Where this situation exists, personnel in each of the various sections tend to concentrate on their own operations with little concern for the operations and problems of personnel in other sections. Group performance under an able supervisor is the main solution to these problems. Obtaining competent sub-supervisors should not be difficult, since the clerks employed in these divisions have obtained an excellent working knowledge of their sections as a result of long experience with the work.

Replacement Training: The hospital routine is on a 24-hour, seven-day basis, while the record keeping procedure is geared mainly to a civilian five-day week. This presents the major problem of replacing civilian employees during their absence or resignation. Many civilians acquire specialties during their period of employment, and are nearly indispensable unless a program of training has been instituted to provide replacements. The constant turnover of enlisted men can also be solved to a great extent by a program of replacement training. Certain functions should always be performed by civilian supervisors and clerks instead of enlisted personnel, to afford continuity which cannot be provided by enlisted personnel. A few "rated" enlisted personnel should be detailed for supervisory training and to assist with the work over week-end periods. Enlisted personnel are particularly necessary in those sections where the pressure of work demands daily supervision for the entire seven days of the week.

#### REPORTS, RECORDS AND FORMS

A thorough study was made of reports required by the Bureau of Medicine and Surgery, as listed in Part V, Chapter 1, Paragraph 513, "Reports" in the Manual of the Medical Department. The findings and recommendations regarding the consolidation or elimination of these reports are discussed separately under each unit of the personnel division wherein the data required on the particular reports are part of the operational steps of that unit.

Similarly, the standard Bureau forms, which have been recommended for revision in view of their inadequacy, are listed under the specific records activities which utilize the forms as part of a procedure.

A review of the local forms to ascertain their essentiality indicates that a large number are obsolete. In addition, the system of format design, reproduction, central control, and general distribution is not satisfactory. In many cases, no provision is made on the forms for the inclusion of hospital register numbers to facilitate identification and eventual filing in patients' jackets. A variety of local forms are used as requests for special examinations and treatment instead of the standard form NAVMFD-HF-57. These requests are for special examinations and treatments on the following: electrocardiograph, physio-therapy, occupational therapy, blood transfusion, X-ray, X-ray therapy, basal metabolism, histopathology, etc. No attempt has been made to make full use of NAVMFD-HF-57, which standardizes the general data and allows for special outlines and forms to be stamped or reproduced on the front and back to cover all possible contingencies.



## METHODS AND PROCEDURES

The volume of work during the war resulted in the development of complex local procedures. Patient loads decreased gradually while hospital staff personnel were demobilized rapidly. Thus the workload was always greater than the available personnel. At present, naval hospitals are operating with reduced patient loads and small staffs while most procedures are still geared for a heavy workload.

The methods and procedures in operation were studied in detail. Various findings and recommendations covering individual units of the personnel division are discussed in the succeeding portions of this report. Specific proposed standard procedures which reflect the results of the findings are described under the applicable section in Appendix I.

Manuals or guides are not available for use in analyzing many procedures. Procedural steps are known, usually, only through a verbal summarization by the specific clerk responsible for a desk or unit. The lengthy experience gained by particular clerks renders them almost indispensable on the job, yet no provision has been made for written manuals to be used for job instruction or replacement training. The evaluation of personnel performance is also made difficult due to the lack of detailed information on work assignments.

## WORK MEASUREMENT AND PERSONNEL REQUIREMENTS

Work measurement on the maintenance of records in naval hospitals is based on procedures. The operating procedures of the personnel and records divisions were analyzed in detail in order to determine their effectiveness and the number of personnel required for each phase of the records-keeping activity. The problem of testing individual performance to determine maximum efficiency and personnel utilization necessitated constant observation and comparison. The employment of civilian clerks in certain positions which demand continuity of service, and the need for military personnel in certain offices over a 24-hour day, seven-day week basis, as compared to the five-day civilian week, are important considerations. The results of the study on procedures indicated, in many cases, that certain sections are overstaffed.

Table 15, "Table of Personnel Requirements", is a summarization of personnel assigned presently to the various units of the personnel and records divisions and the miscellaneous services related to records keeping, together with the personnel requirements in view of the proposed reorganization and procedures for the personnel division. A pattern for standard staffing is indicated in table 16. Comparative statistics on past staff performance are available in table 17. Reductions of from 11 employees in medium hospitals (patient load of

400) to 19 employees in larger hospitals are reflected in the table. The savings per hospital range from \$27,500 to \$47,000 in annual salaries, based on an average annual salary of \$2,500.

#### RECOMMENDATIONS

1. The present organizational structure of naval hospitals should be revised to include all personnel activities, staff, patient and civilian, under one division, entitled "Personnel Division" (Exhibit 16).
2. The personnel officer of the reorganized personnel division should appoint supervisors for each operational unit of the division and delegate authority and responsibility to them for the flow and output of work in their respective units.
3. A "replacement-training" program should be planned and activated immediately for the various units in the personnel division, including the records office, to prevent interruptions in work flow and output due to the absence or turnover of civilian and enlisted personnel.
4. The Bureau should work with the hospitals on a program to review all local forms to determine essentiality, eliminate obsolete forms, consolidate duplicating forms, revise necessary local forms to include register numbers, and revise the numbering system of local forms for control purposes.
5. All hospitals should utilize the standard form NAVMED-HF-57, Special Examination and Treatment Request, and eliminate the use of local forms in connection with special treatment and examination requests.
6. The proposed procedures should be used as the basis for preparing internal procedural manuals or job instruction guides as aids in job indoctrination or replacement training (Appendix I).
7. The proposed standard staffing requirements outlined in Table 16 should be utilized.



ELIMINATION OF FORMS AND REPORTS IN ONE DIVISION

PERSONNEL DIVISION

Present

Proposed

REPORTS

- |  |  |
|--|--|
| 1. Periodic Morbidity Reports (weekly, monthly, etc.)  | Utilize IBM accounting system at Bureau.<br>Discontinue periodic reports.  |
| 2. Receipt, Transfer and Status Card, NAVMED-HC-3.   |  |
| 3. Roster Report of the Hospital Corps, NAVMED-HC-4.   |  |
| 4. Admission or Discharge of Officer, NAVMED-HF-1.   |  |
| 5. Roster Report of the Medical Corps, NAVMED-953.   | Use BuPers accounting system (NAVPER-500 and 501, Daily Diary) revised to include a few items not now included. Eliminate present forms.                         |
| 6. Weekly Report of Enlisted Hospital Corps, USN/USNR on Board for Duty and Instruction (letter report). |  |
| 7. Weekly Report of Assignment and Housing of Hospital Corps Personnel (letter report).                  | Discontinue - Housing data in report (7) is included in Bureau's Hospital Bed Capacity Report; assignment data available in the Daily Personnel Diary.           |
| 8. Annual Syphilis Report, NAVMED-A.   | Eliminate - BuMed receives information on each syphilis case, and developments in anti-syphilitic drugs plus accumulated statistics render this report obsolete. |
| 9. Interim reports to Veterans Administration.   | Eliminate interim reports since complete clinical histories are furnished Veterans Administration.   |
| 10. Veterans Administration reports and forms completed for convenience of Veterans Administration.      | Discontinue, since this is a responsibility of Veterans Administration.  |

# ELIMINATION OF FORMS AND REPORTS IN ONE DIVISION

## PERSONNEL DIVISION

BY FUNCTIONAL UNIT  
FOR THE PERSONNEL AND RECORDS DIVISION

Present	Proposed
<p>Present Based on Recommended            Subjected to Local Variations            001 001 001 001  <b>FORMS</b></p>	<p>Present Assigned in            Hospitalized            001 001 001 001            001 001 001 001</p>
<p>1. Variety of Admission Cards, with supplementary forms and memos (e.g., Muster Card, NAVPERS-617).</p>	<p>Standard Admission Card with provision for adequate distribution of copies. Discontinue local forms and memos.</p>
<p>2. Various examination and treatment requests.</p>	<p>Special Examination and Treatment Request, NAVMED-HF-57. Discontinue local request forms.</p>
<p>3. Local transfer forms and transmittal letters.</p>	<p>Standard Transfer Order, NAVPERS-563/NavSanda Form-36. Discontinue use of present forms in this connection.</p>
<p>4. Transfer of Men, NMSH-Form 3.</p>	
<p>5. Orders to Transfer Accounts, NMSH-Form 4.</p>	
<p>6. Order for Transfer, NMSH-Form 5.</p>	
<p>7. Order for Transportation, NMSH-Form 7.</p>	



TABLE 15

PERSONNEL REQUIREMENTS FOR THE PERSONNEL AND RECORDS DIVISION  
BY FUNCTIONAL UNITS

Patient Load	Present Assignments in Hospitals Studied			Recommended; Based on Proposed Pro- cedures Subject to local Variations		
	400	700	1250	400	700	1250
<u>BuMed Section</u>						
F Card Desk	1C	1N	2C	(1C	(1C	(1C
Morb. Reports Desk	1C	1C	1N	( -	(1N	(1N
Form 36 Desk	1C	1C	1N	-	-	1N
Form 10 Desk	1N	3N	1C (1N	(1C	(1C	(1C
Med. Hist. Write-up	1C (1N	2C	(2C (1N	(1C (1N	(1C (1N	(2C (1N
Health Record Custody	1N	1N	1N	( -	( -	( -
Medical Survey Desk	1C	2C	2C (2N	1C	1C	1C (1N
Supernumerary Desk	1C	1C	1C	(1C	1C	1C
Vet. Adm. Pat. Desk	1N	-	3C (1N	( - -	1C	2C
<u>BuPers Section</u>						
Enl. Patient Rec'pt Desk	1N	(1C (1N	(2C (1N	1N	1N	(1C (1N
Enl. Patient Transfer Desk	1C	(1C (1N	(3C (3N	(1C	(1C (1N	(1C (1N
Enl. Patient Discharge Desk	1N	(1C (1N	(1C (1N	( -	1C	1C
Officer Patient Desk	(1C	1C	(1C (1N	(1C	1C	1C
Deaths Desk	( -	1C		( -	1C	1C (1N
Leave Desk	-	1N	1N	1N	1N	1N
Personnel Acctg. Desk	1N	2N	(2C (1N	1N	2N	2N
<u>Military Personnel Section</u>						
HC-3 and -4 Desk	2N	2N	1N	1N	1N	2N
Detail Desk	1N	3N	1N	1N	2N	4N
Staff Officer Desk	1C	1C	2C	-	(1C	(1C
Staff Reports Desk	1C	1C	1N	-	( -	( -
Staff Enl. Receipts, Trans., Dischs. Desk	1N	(1C (1N	3N	1N	1N	2N
<u>Civilian Personnel Section</u>						
Misc. Activities	3C*	3C*	4C*	2C	3C	5C
<u>Miscellaneous Services</u>						
Admission Unit	4N	6N	5N	4N	4N	5N
Bag Room	3N	3N	3N	2N	2N	3N
Information Desk	1N	1N	1N	1N	1N	1N
Central Files Unit	(1N 2C	3C	6N	2C	3C	(2C (1C
Mail Directory Service	2N	(2N (1C	1C	1C	1C	1C
Totals	37	51	64	26	36	50

C - Civilian Personnel  
N - Navy Enlisted Personnel  
\* - Estimated Staff

TABLE 16

## PROPOSED STANDARD STAFF REQUIREMENTS FOR PERSONNEL DIVISION

<u>Patient Load</u>	<u>Staff per Patient</u>	<u>Total Staff Required</u>	<u>% Military (Approximate)</u>
200	0.080	16	50
400	0.065	26	50
600	0.055	33	50
800	0.050	40	50
1,000	0.046	46	50
1,200	0.043	51	50
1,400	0.040	56	50
1,600	0.038	61	50
1,800	0.036	65	50
2,000	0.035	70	50

Includes: Patient Records (officer, enlisted, and supernumerary)  
 Bag Room  
 Admission Unit  
 Information Desk  
 Central Files Unit  
 Mail Directory Service  
 Military Personnel (plus Education and Civil Readjustment)  
 Patient Details  
 Civilian Personnel



TABLE 17

## \*PERSONNEL AND PATIENT RECORDS - PAST PERFORMANCE

<u>Date</u>	<u>PORTSMOUTH</u>		<u>PHILADELPHIA</u>		<u>GREAT LAKES</u>		<u>SAN DIEGO</u>		<u>NEWPORT</u>	
	<u>Staff</u>	<u>Staff per patient</u>	<u>Staff</u>	<u>Staff per patient</u>	<u>Staff</u>	<u>Staff per patient</u>	<u>Staff</u>	<u>Staff per patient</u>	<u>Staff</u>	<u>Staff per patient</u>
<u>1946</u>										
Jan	75	.063	99	.033	328	.044	181	.043	61	.051
Feb	68	.057	106	.039	321	.052	147	.037	60	.054
Mar	55	.051	114	.044	287	.058	149	.043	60	.056
Apr	58	.058	108	.044	215	.049	165	.054	58	.066
May	58	.062	102	.045	192	.050	217	.090	54	.073
Jun	44	.050	102	.051	188	.058	188	.097	41	.066
Jul	42	.049	92	.050	146	.053	120	.068	37	.061
Aug	40	.064	77	.049	178	.083	111	.066	39	.070
Sep	39	.067	55	.038	135	.083	99	.063	37	.061
Oct	35	.066	60	.043	101	.080	92	.059	39	.064
Nov	32	.069	64	.049	68	.058	80	.057	38	.068
Dec	(461 Patients)		54	.044	63	.062	86	.060	37	.073
<u>1947</u>										
Jan			53	.044	58	.062	81	.057	32	.058
Feb			47	.038	63	.072	83	.060	31	.049
Mar			(1240 Patients)		(880 Patients)		76	.057	32	.050
Apr							(1350 Patients)		35	.053
									(650 Patients)	
<u>PATIENTS</u>										
3000				.036		.054				
2500				.044			.054			
2000				.045		.083	.090			
1600				.048		.083	.097			
1200		.060		.042		.083	.065			
1000		.057				.069	.058			.052
800		.050				.062				.056
600		.066				.072				.069
400		.069								.062

\* Does not include Civilian Personnel Section.

## ADMISSION UNIT

The admission units of the hospitals are well located. They are part of or immediately adjacent to the main hospital building with provision for easy access from the hospital compound road to the unit entrance. There are two separate admission units; one for Navy and Marine personnel and supernumeraries, and one for dependents. Adequate space has been provided for the admission of patients, including individual examination rooms, emergency infirmaries, wards, quarters for the sleep-in watch, and office facilities for the medical officer on duty.

The functions of admission units are to:

- a. Register the admission of the patient.
- b. Assign the patient to the proper ward according to his diagnosis, after verifying the patient's entitlement to hospitalization.
- c. Check all records and official documents accompanying patients, and route these documents properly.
- d. Insure proper sealing, tagging, and disposition of patient's baggage.
- e. Initiate proper forms, upon admission of patient.

Personnel assigned to the admission unit are under the immediate supervision of the medical officer on duty, but are administratively responsible to the personnel officer. Personnel assigned for professional duties, as assistants, are responsible to the duty officer. The efficiency of personnel in the admission unit, particularly the accuracy with which initial forms and reports are prepared, is reflected in every subsequent phase of record-keeping. It is very necessary, therefore, that well-qualified and capable personnel are assigned to the admission unit. The staff for this activity should consist, generally, of a chief pharmacist's mate and corpsmen assistants.

## METHODS AND PROCEDURES

Local Admission Cards: A detailed study of several admission procedures reveals the vital importance of, and the necessity for, a standardized Admission Card. Each hospital has attempted to solve the problem of obtaining essential information on the admission of a patient and disseminating this information to cognizant activities by using a local Admission Card. The inadequacy of local admission cards is evidenced by the preparation of various memoranda in multiple copies, other entries to supplement the local card, and "muster" file cards.



The information obtained from the patient at the time of admission provides the basis for all subsequent pertinent forms, reports, records, and card indexes. It is extremely important that this initial information be listed quickly on a compact and complete form so the patient can be placed immediately on a ward for treatment.

Certain activities of the hospital, such as the wards, information desk, mail directory service, and several sections of the record office need basic admission information at the beginning of each work-day, covering the period through 2400 of the previous day. These activities are constantly working against time in the preparation of daily reports. Detailed information must be available each morning, as early as possible, for the daily preparation of individual patient statistics, compilation of morbidity data, transmittal of personnel data to the Bureau of Naval Personnel, dissemination of information in connection with requests regarding patients' conditions, and the distribution of patients' mail.

Proposed Admission Card: It is proposed that a standard Admission Card, which is a composite of the local admission cards, be adopted for all hospitals (Exhibit 17 and attached key regarding use of form). The card was designed after many discussions with records officers and other hospital officials. In addition, the following new features have been incorporated:

- a. Size of the form is adequate to provide sufficient space for required information and at same time adhere to a standard Kardex size.
- b. "Snap-out" type, to allow for clear carbon copies and to facilitate typing.
- c. "Rainbow-color" copies, to assist in rapid and orderly distribution of copies. (Ex. 17A)
- d. Flexibility in use of the form. The same form can be used for dependent's service admissions, and for recording admission data on supernumeraries and Veterans Administration patients, as well as for Navy and Marine patients. A hospital check-out is also provided on this form.

The records office procedures recommended for standardization include the use of a minimum number of copies of the Admission Card for "muster" purposes, thus eliminating the excessive quantity of small file cards and special muster cards currently used at several desks. Since the new cards will not be removed after they are inserted in the Kardex at the end of the day, until the patient is discharged, the size and light weight of the paper will not prove a hindrance. Space has been provided on the admission form for adding any specific information desired on patients not already provided for. The card will contain information initially obtained by admission personnel and data added subsequently to complete this basic record.

Inventory of Patient's Gear: Paragraph 516.2 of the Manual of the Medical Department requires that NAVMED-G (Hospital Ticket) or NAVMED-416 (Hospital Ticket - Women) shall be examined, and the patient's clothing and effects shall be checked against the list on the front of the form for verification or correction. This procedure has proved to be impractical. In most instances, the "Form G" is received with the information "not inventoried" appearing on the face of the form. Valuable time is spent by either the duty officer or record clerk in listing or checking for minor pieces of clothing and effects, and the inventory is seldom, if ever, thoroughly accurate. In many instances, the patient is admitted before the personal effects are received.

A more preferable method of accounting for gear would be for the activity transferring the patient to seal the patient's personal effects, and post the number of the seal to the hospital ticket prior to the patient's transfer. Admission unit personnel should seal the baggage upon receipt at the hospital if this function is not accomplished at the duty activity. Each time the baggage is opened during the patient's hospitalization, for either withdrawal or deposit of personal effects, a new seal should be applied.

The Portsmouth Naval Hospital and the Great Lakes Training Center are using this system with success. The suggestion that metal seals be used for sealing personal effects was received with enthusiasm at other hospitals. In connection with the metal seals, it was ascertained that various naval stations carry these items in stock in considerable quantities, simplifying the supply problem.

Recommended Standard Admission Procedure: As a result of the study of the admission procedures, the types of patients admitted have been summarized, and a standard admission procedure is recommended for adoption (Appendix I). The better features of the several admission procedures studied, as well as additional recommendations listed in this section of the report, have been incorporated in the standard procedure. The adoption of this procedure will result in more efficient admission work, which, in turn, will be reflected in almost every record-keeping operation.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

The average type of patient reporting for hospitalization can be placed on a ward for treatment in 15 or 20 minutes, if his diagnosis has been determined at the duty station. With allowances for considerable leeway in the preparation of the Admission Card and baggage



tag, sealing the baggage, and making necessary entries in the register and log, the following staff is adequate for admission units:

No. of Daily Admissions

15-20

20-40

Staff Necessary

4 (including CPhM)

5 (including CPhM)

These figures allow for personnel working on a 24-hour basis, seven days a week, standing the usual port, starboard, and night watches.

RECOMMENDATIONS

1. A chief pharmacist's mate should be detailed as supervisor of each admission unit.
2. Hospital Corps personnel should be assigned as clerks in these units, rather than civilian clerks who are only on duty five days a week. Three corpsmen, in addition to the chief, will be required if the number of daily admission averages 15 and 20; and four corpsmen, if the average is between 20 and 40.
3. The proposed Admission Card (Exhibit 17) should be adopted as a standard form, thus eliminating the printing of a variety of local Admission Cards.
4. Metal seals, numbered serially for purposes of identification, should be used in lieu of the present system of checking personal effects of patients against the hospital ticket.
5. Upon the adoption of the standard Admission Card procedure the various memoranda, local file cards, and miscellaneous logs currently being used should be eliminated.

# EXHIBIT 17

1.	NAME (a) (Last) (First) (Middle) (d)										WARD										ADMISSION CARD NAVMED-																																																																																									
2.	(b) (c) (d)										U.S. NAVAL HOSPITAL (e)																																																																																																			
3.	SERVICE OR FILE NO. (f)										RANK, RATE OR CLASSIFICATION (g)										WARD (h)										BLOOD TYPE (j)										RECEIVED FROM (k)										HOSP. REG. NO. (l)																																																											
4.	DATE (m)										IF PREVIOUSLY ADMITTED, GIVE DATE (n)										PLACE OF FIRST ENLISTMENT (o)										DATE OF FIRST ENLISTMENT (p)										EXPIRATION OF PRESENT ENLISTMENT (q)										KEY LETTER (r)										SPECIALTY LETTER (s)										SICK DAYS (t)																																							
5.	DIAGNOSIS NO. AND TITLE (u)										CIRCUMSTANCES OF OCCURRENCES (v)																																																																																																			
6.	AVIATION STATUS? (w)										SEX (x)										MARITAL STATUS (y)										BIRTHPLACE (z)										DATE OF BIRTH (aa)										LEGAL RESIDENCE AND LENGTH OF TIME (bb)																																																											
7.	MAIDEN NAME OF MOTHER (cc)										BIRTHPLACE (dd)										NAME OF FATHER (ee)										BIRTHPLACE (ff)																																																																															
8.	NAME AND ADDRESS OF NEXT OF KIN (gg)										RELATIONSHIP (hh)										NEAREST PHONE (ii)										GOVERNMENT INSURANCE (jj)										YES (kk)										NO (ll)																																																											
9.	NAME AND ADDRESS OF BENEFICIARY (kk)										STATE HOW PATIENT ARRIVED (By Priv. Auto, Mil. Vehicle, etc.) (ll)										WAS ACTIVITY NOTIFIED? (mm)										DISCIPLINARY STATUS LTR (nn)										YES (oo)										NO (pp)																																																											
10.	INDICATE TYPE (AOL, AWOL, SCM, GCM, etc.) (oo)										RECORDS REQ'D (CHECK), REQUESTED (DATE) (pp)										HR (qq)										CSC (rr)										FORM G (ss)										ORDERS (Other) (tt)										AUTHORITY FOR ADMISSION (Others) (uu)																																																	
11.	OFFICER'S PAY AC CARRIED WHERE (rr)										DISPOSITION, DATE, AND AUTHORITY (ss)										RECORDS FORWARDED (CHECK) (tt)										HR (uu)										CSC (vv)										FORM G (ww)										ORDERS (Other) (xx)																																																	
12.	REMARKS (yy)																																																																																																													
13.	NAME (vv)										SERVICE OR FILE NO. (ww)										RANK, RATE OR CLASSIFICATION (xx)										WARD NO. (yy)																																																																															
BINDING EDGE																																																																																																														
<p>(BACK OF FORM - Ward Copy ONLY)</p> <p style="text-align: center;"><u>CHECK OUT</u></p> <table border="1"> <tr> <td>WARD M.O.</td> <td>BAG ROOM</td> <td>LIBRARY</td> <td>MAIL ROOM</td> <td>PAY OFFICE</td> <td>RECORDS OFFICE</td> <td>V.A.P. DESK</td> <td>AGENT CASHIER</td> <td>O.O.D.</td> </tr> <tr> <td colspan="8"></td> <td>(Time)</td> </tr> </table>																																								WARD M.O.	BAG ROOM	LIBRARY	MAIL ROOM	PAY OFFICE	RECORDS OFFICE	V.A.P. DESK	AGENT CASHIER	O.O.D.									(Time)																																																					
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Original and six copies to be completed at Admission Desk.

## DISTRIBUTION:

1. WARD (White)
2. INFORMATION DESK (Light Blue)
3. RECORD OFFICE (Green)
4. RECORD OFFICE (Salmon)
5. RECORD OFFICE (Buff)
6. MAIL ROOM (Pink)
7. ADMISSIONS (Yellow)

(Individual snap-out carbons will be used for this form; the copies will be on thin tough paper stock to enable typing in one operation)





A KEY TO THE USE OF THE PROPOSED ADMISSION CARD

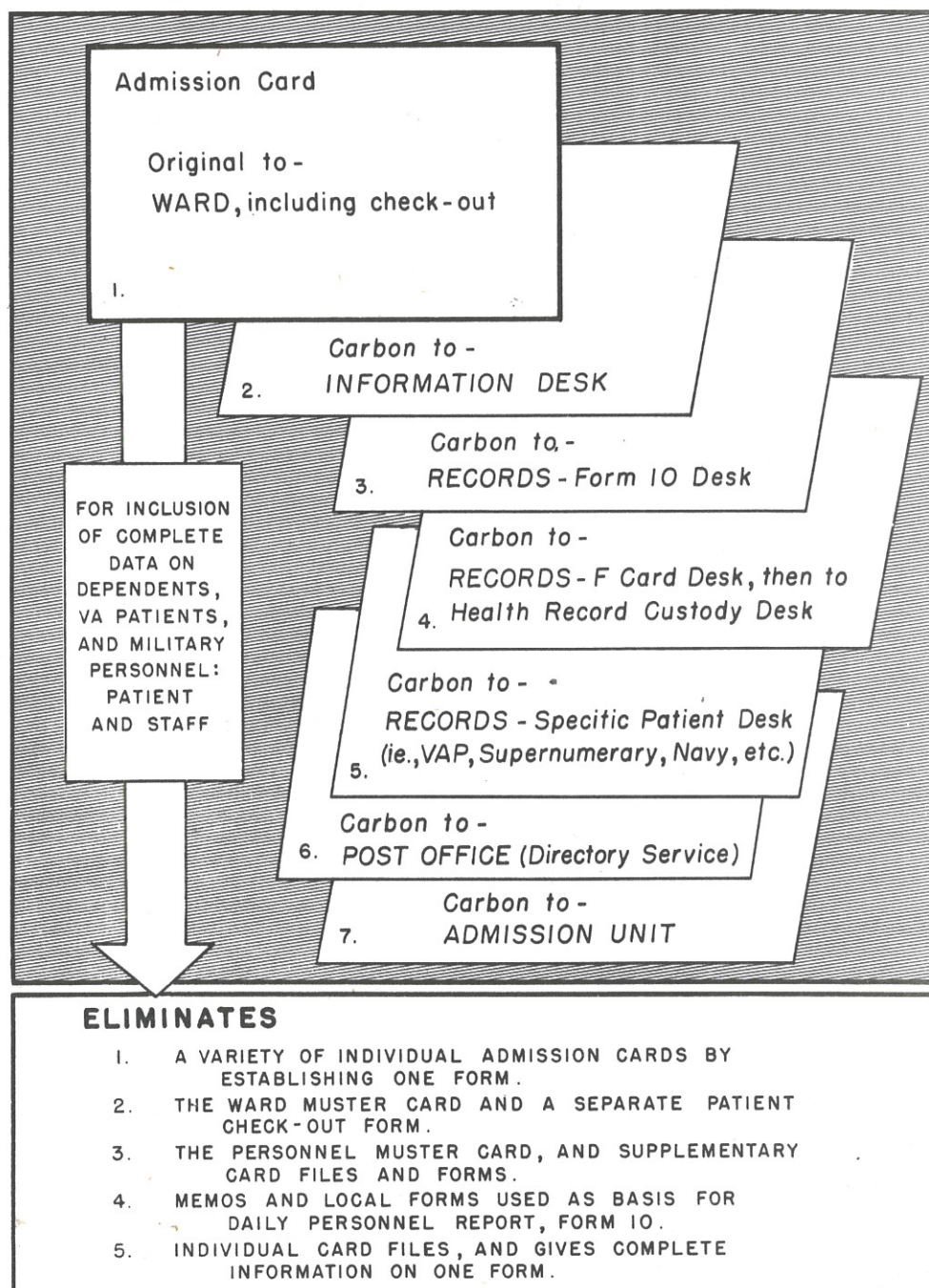
(Each rainbow copy will include the printed destination of the particular copy)

- Lines 1 and 2 (a), (b), (c) - Post individual identification data and information for "F" card.
- Line 2(d) - Insert number of assigned ward.
- Line 2(e) - Insert location of the particular hospital.
- Line 3(f), (i), (k) - Post information for "F" card.
- Line 3(g) - Post information which furnishes specific data for Ration Record, NAVMED-HF-36.
- Line 3(h) - Enter information for Form 10 (chaplain's office), in case of serious or critical list, or death.
- Line 3(j) - Insert information for possible blood transfusion while on ward.
- Line 3(l) - Insert hospital register number as additional identifying item which will appear on all hospital forms for this particular patient.
- Line 4(m) - Enter "Yes" or "No" for "F" card ("EPTE" stands for Existing Prior to Entry).
- Line 4(n) - Post information for "F" card.
- Line 4(o), (p) (q), (r), (s), (t) - Enter information for record office activities, "F" card and Bureau of Naval Personnel data.
- Line 5(u), (v) - Post information for "F" card.
- Line 6(w), (z), (aa) - Post information for "F" card.
- Line 6(x), (y) - Insert information for possible social service.
- Line 6(bb) - Post information to prove eligibility for State benefits (political).
- Line 7(cc), (dd), (ee), (ff) - Enter information needed to complete record.
- Line 8(gg), (hh), (ii) - Enter information needed in case of serious or critical list, or death.
- Line 8(jj) and Line 9(kk) - Post information necessary on Veterans Administration patients, especially.
- Line 9(ll) - Insert information necessary in case of damage suits, compensation due from Veterans Administration, private ambulance service, etc.
- Line 9(mm) - Insert information necessary in case of servicemen emergency cases.
- Line 10(pp) - Provides a permanent record of official documents received (indicate with check), and proof of eligibility for admission unit. Indicate request for records by noting the date in the appropriate box.
- Line 9(nn) and Line 10(oo) - Provides permanent record of vital information regarding disciplinary action cases.



- Line 10(qq) - Provides permanent record of official documents proving eligibility received in case of supernumerary patients.
- Line 11(rr) - Post information necessary for preparation of Hospital Ration Notice, NAVS&A-534, regarding subsistence of officer patients.
- Line 11(ss) - Provides information for "F" cards on dependents, and other data on disposition, including authority.
- Line 11(tt) - Provides permanent record regarding forwarding of official documents in case of discharge, transfer, etc.
- Line 12(uu) - Provides space for additional data on all patients, particularly dependent patients, i.e.:  
Home address of dependent patient.  
Name of serviceman on whom patient is dependent.  
Relationship of dependency.  
Ship or station and location of person on whom dependent.  
Approximate period of hospitalization.  
Social Security Number (optional).
- Line 13(vv),  
(ww), (xx) - Same as Line 1 and 2(a),(b),(c). Individual identification, particularly necessary when visible Kardex system is used.
- Line 13(yy) - Provides information at all times as to location of patient, particularly in case of interward transfers. Numbered or lettered tabs could be used as current ward indicators.
- Line 14 - Provides space as applicable, for check-out from hospital. (Includes agent cashier for supernumeraries and dependents.)

## DISTRIBUTION OF PROPOSED STANDARD ADMISSION CARD



Drawn by MEDICAL STATISTICS DIVISION





## BUREAU OF MEDICINE AND SURGERY SECTION

### ORGANIZATION

The title "Bureau of Medicine and Surgery Section" is applied arbitrarily to the desks comprising this section since the statistics prepared are primarily for the Bureau of Medicine and Surgery. The functions of this section include the compilation of personnel, morbidity and ration data received from various sources within the hospital; the preparation of various forms and reports required locally or by the Bureau; and the custody and maintenance of patients' Health Records, and their distribution to the cognizant clinical departments. The operational steps involved are described fully in the Appendix.

Although the size of this section will vary from hospital to hospital, depending on patient load, the results of the survey reveal that certain basic titles are applicable to the various desks. These "desks" are usually grouped physically in the same area, and bear the following designations:

- a. F Card Desk
- b. Morbidity Reports Desk
- c. Form 10 Desk (Daily Personnel Report)
- d. Form 36 Desk (Ration Record)
- e. Health Record Custody Desk
- f. Medical Survey Desk
- g. Medical History Write-up Desk
- h. Supernumeraries Desk
- i. Veterans Administration Desk

### PERSONNEL

A clerk having a high degree of specialized experience and continuity of service should be responsible for the preparation of "F" and "Fa" cards (NAVMED-F, Individual Statistical Report of Patient), instructions for which are outlined in the Bureau of Medicine and Surgery's "Fa Procedural Manual". It is also necessary that an experienced person supervise this desk, and other desks in this section, in order to assure the proper coordination of information required for the compilation of various types of statistics.

Rated corpsmen, if necessary, can perform the duties at the morbidity reports, "Form 10", "Form 36", and Health Record custody desks. Civilian clerks are preferable for the medical



survey and medical history write-up desks, both of which require long experience for accurate performance. Extensive experience and thoroughness in medical survey preparations on the basis of survey board reports and decisions is necessary for the proper evaluation and summarization of medical histories. Civilian clerks are also desirable on the supernumeraries and Veterans Administration desks, because continuity of service is again necessary to acquire experience in the intricate details involved in maintaining records and preparing reports on these patients.

#### METHODS AND PROCEDURES

F Card Desk: The "q" and "qa" cards are typed from data on the Admission Card, and the patient's Health Record to serve as reports to the Bureau of each admission, change of diagnosis, and final disposition of a patient from the sick list. The detailed operations in connection with this form will not be discussed, since the procedures outlined in the "qa Procedural Manual" are being closely followed.

Failure of Medical Officers to Adhere to Standard Navy Nomenclature: A delay in record-keeping work results from the negligent preparation of the standard Change of Diagnosis, NAMED-HF-53, and the failure of many ward medical officers to use properly the prescribed standard Navy diagnostic nomenclature in the recording of changes of diagnoses on patients' Clinical Charts. Copies of the standard Navy nomenclature are available on all wards for medical officers' reference.

Changes of diagnoses are normally prepared on the ward by the ward medical officer. It is necessary that chronological entries be made in the patient's Clinical Chart for the proper summarization of the medical history when abstracts are prepared subsequently, and for a notice to be sent to the records office in order that the proper statistical form may be forwarded to the Bureau. Records officers require that the patient's chart be released from the ward, and delivered to the records office by the ward corpsman. This procedure is established to overcome the ward medical officer's improper use of diagnostic nomenclature, inaccurate preparation of notices to the records office, and often failure to include the change entry in the patient's chart.

All the steps in the changes of diagnoses are checked for completeness and accuracy immediately by a records clerk. The chart is then returned to the ward by the corpsman. If errors have been made, the chart must be returned and the process repeated. The removal of



the chart from the ward affects patient service. Valuable time is lost by the war corpsman when he reports to the records office with the chart and change notice, and, in turn, time is lost by the records office clerks in checking the papers. (The proposed F Card, Change of Diagnosis, and Morbidity Report Procedures appear in Appendix I.)

Morbidity Reports Desk: The clerk at this desk maintains comprehensive daily worksheets on which daily units representing diseases of patients may be entered from "F" cards according to diagnostic class and selected diagnosis.

The daily unit totals are transcribed to the statistical morbidity reports. The Weekly Report of Communicable Diseases, NAVMED-172, includes the number of staff personnel taken up on the sick list with certain specific communicable diseases, and the average strength of staff personnel. The Monthly Morbidity Report, NAVMED-582, shows the staff personnel who have been admitted to the sick list during the month, and the transient or temporary personnel received from other activities for hospitalization. It includes a detailed listing of all diseases taken up according to the diagnostic class and selected diagnosis, separated into 95 different classes, showing each admission and change of status (admission, re-admission, etc.) occurring during the month, classified as officers, enlisted personnel, and supernumeraries.

Since these data are the basis upon which the Bureau evaluates current morbidity trends for planning or controlling certain preventive medicine progress, the essentiality of certain information which is submitted weekly and duplicated in a monthly report is a matter of Bureau decision. No evidence was revealed in the survey that Bureau statistical publications received, as a result of these morbidity reports, were used by the hospitals to any extent.

#### REVISION OF "Fa" CARD PROCEDURE

Individual statistics on patients are submitted to the Bureau in accordance with procedures outlined in the standard Fa Procedural Manual, which requires that "Fa" cards be prepared and forwarded only at the time a "disposition" of the patient occurs (i.e., change of diagnosis, discharge, death, etc.). This method furnishes information on patients on whom at least one change of diagnosis has taken place, but not all patients admitted to the hospital.

In addition to these "Fa" cards, hospitals are required to furnish the previous mentioned periodic morbidity reports. These reports represent a summarization of patients "disposed of", as well as those admitted. The hospitals must maintain running compilations of both admissions



and dispositions in order to prepare these reports. This process is complex, time consuming, and represents much waste effort due to the duplication that occurs.

It is apparent that if the "Fa" cards were submitted to the Bureau immediately upon admission of a patient, and for every disposition that occurs, the Bureau would have current statistical cards on all patients and would be in a position to receive tabulations from the accounting machines for any desired purpose. The preparation of statistical publications could be accomplished with little effort in the Bureau, and hospitals would be required to submit only the necessary card records.

Form 10 Desk: A daily personnel report (formerly NAVMED-HF-10) is still being prepared for local use on a form similar to the original, although it is no longer required by the Bureau. This report is a compilation of statistics on all staff patient personnel in the form of a bed census, classification of patients, census of patients, and a census of attached staff personnel data. It also includes detailed listings of patients admitted and discharged, by name. The report is distributed widely to the departments and services and provides valuable information necessary in the preparation of other reports. The exact distribution depends on the size of the hospital, location, and other local factors.

Information for the Form 10 is received from the Ward Report (NAVMED-HF-9), recapitulations, admission cards, and memoranda from several sources. The "Proposed Form 10 Desk Procedure" in Appendix I outlines this operation in detail.

The work of several sections of the record office is retarded due to the delay in receiving copies of the Form 10 on schedule. Since this report is the basis for much information necessary in the daily preparation of forms and reports by other sections, it is evident that any delay in its preparation is a waste of valuable man-hours and funds. In one hospital, as much as four hours' delay exists before the Form 10 is completed. The chief reason is that information received each morning from the various wards is incorrect or incomplete. "Transfers to" one ward, for instance, is not reflected as "Admitted to" another ward. Total census figures for a particular report do not agree with figures of the previous day from the same ward, even after all changes have been listed. Much of this is due to carelessness on the part of the nurse preparing the report. As a result, numerous telephone calls have to be made to wards in order to correct the discrepancies. In larger hospitals which contain as high as 30 wards, this situation is quite serious, but it continues despite constant reminders from records officers.



Form 36 Desk: The duties of this desk include the compilation of statistics on the number of rations consumed, rations sold, and collections for rations. These data are tabulated for the Bureau monthly, on a standard Ration Record, NAVMED-HF-36.

Daily tabulations must be kept in order to obtain accurate data for the monthly report. Individual file cards on all officers, staff and patients "subsisting in" and "subsisting out" must be maintained, since changes occur daily. Personnel on leave must be included in the daily compilation. A Hospital Ration Notice, NAVS&A-534, is required for pay checkage purposes. At the end of the month, the commissary division submits a report on the number of rations sold and the agent cashier furnishes a report on the status of collections from supernumeraries and dependents.

The demobilization of active service personnel is rapidly being completed, and many of the personnel categories existing during the war should no longer appear on the ration record. This has no direct bearing on the preparation of the report, but the detailed breakdown must still be considered in the daily compilation of figures and involves more work. (Proposed procedures appear in Appendix I.)

Weekly Report of Patients (NAVMED-I): This report is also prepared by the Form 36 desk, since the preparation of the ration record is not a full-time duty. Further, the NAVMED-I logically belongs in this section because of its close relationship to other statistical reports prepared for the Bureau.

The weekly report of patients contains detailed statistics on the availability of bed space at the hospital, and an explanation of the utilization of this bed space among the several categories of patients being treated. In addition, there is information concerning the "K" casualty patients (patients with injuries received in action against an organized enemy) received, discharged, and remaining. The number of amputees, dead, and blind patients are also appended to this report as a separate memorandum.

The compilation of the NAVMED-I includes details on admissions, discharges, and the bed census from the daily Form 19. It is prepared once a week, as of midnight each Wednesday and is due at the Bureau on Friday.

Figures for the bed census are obtained from the Form 10 desk, where ward reports are received daily showing the number of beds on each ward, the number of patients in each service, and the number of beds unoccupied. The figures are checked for the Wednesday midnight census, reclassified to conform with the information required on the NAVMED-I, and entered on the report form.



To assure accuracy of this report, frequent contacts are made with units having jurisdiction over the various categories of patients, such as Veterans Administration desk, super-numeraries desk, and dependents service, to compare the number of patients on their records with the number to be submitted on the report.

Health Record Custody Desk: All Health Records received on patients admitted with official documents, as well as those papers subsequently received from duty stations, are received by this desk and accounted for on file receipt cards. The Health Record is used in various divisions and services of the hospital. In order to control its use, an accurate charge-out record is maintained. Upon discharge of the patient, the disposition of the Health Record is officially recorded. (Proposed procedures appear in Appendix I.)

Patients' health records are transferred among several desks in the records office, and among various clinical services during the patients' hospitalization. Since these documents contain the medical histories of all Navy and Marine patients from the date of their entry in the service, they represent a considerable investment in time and effort. If they are misplaced or lost during the patients' stay in the hospital, it takes considerable effort to replace them. The necessity for a location receipt or "tally" form is therefore obvious.

Some form of "tally" card, either a small card or a form designed by the local district printing office, is used at present in the Health Record or Service Record file, but a standard receipt card should be available.

Venereal Disease Reports: Two reports, the Annual Syphilis Report for the Year\_\_\_\_\_, NAVMED-4, and the Venereal Disease Contact Report, NAVMED-171, are also prepared by this desk as required. The syphilis report is prepared from the health records of persons on board who have, or have had, a history of syphilis. The contact report is prepared on each case admitted with this type of diagnosis.

Individual statistics on a patient are forwarded to the Bureau on "Fa" cards upon the transfer of a patient with a syphilis diagnosis. Subsequently, an Abstract of Antiluetic Treatment, NAVMED-H-7, is prepared for the patient's health record only, showing treatments administered the patient with the dosage of penicillin or arsenicals. A letter is forwarded to the Bureau containing information which explains the reactions in detail. On subsequent dispositions an "Fa" card is forwarded.

Considerable information is already being received by the Bureau of Medicine and Surgery on each syphilis case. Much duplication of effort is involved in preparing the annual

syphilis report. This can be eliminated by adopting the recommendations pertaining to the Health Record custody desk appearing at the end of this section of the report.

In addition, consultations with medical officers familiar with the NAVMED-A form and its original purpose, i.e., to determine the percentage of serious treatment reactions to various drugs, revealed that this form has been rendered obsolete by developments in antisyphilitic drugs since August 1945, and the great amount of information already gained for "checking" purposes through statistics accumulated during the past years.

Medical Survey Desk: When the ward medical officer decides that a patient should appear before a local medical survey board, the details are handled by the medical survey desk. The ward medical officer is required to check his roster of patients periodically, to decide cases of officers who have been hospitalized locally or at other naval hospitals a total of not more than 90 days, and of enlisted personnel who have been hospitalized a total of not more than six months. File indexes on each survey case are maintained for ready reference. Endorsements on surveys forwarded to the Bureau of Medicine and Surgery for approval are determined in accordance with existing directives.

The time element between the date of eligibility for discharge and the actual discharge of survey cases was studied at length. With the exception of the time required for patients to await the Bureau of Medicine and Surgery's approval of the local survey board's decision, the procedure is efficient and rapid. A definite schedule of meetings on particular types of cases are adhered to rigidly. All records and reports are prepared on schedule, and patients are fully advised of their prerogatives. From three to six weeks are necessary for Bureau approval. Upon receipt of approval, patients are discharged in four days' time, including civil readjustment interviews, Veterans Administration assistance, and other phases of the separation program.

No problems exist in connection with survey procedures due to the rapid decline in the number of survey cases. As indicated above, however, steps should be taken to expedite the receipt of Bureau approval on medical surveys.

The Report of Survey, NAVMED-M, is typed from "rough" survey reports, and distributed in accordance with procedures outlined in "Proposed Medical Survey Desk Procedures" (Appendix I).

Medical History Write-Up Desk: Abstracts of medical histories are completed at this desk. This work involves a thorough comprehension of medical terms, knowledge of the continuity



of patients' treatment, and an ability to summarize voluminous data. The civilian personnel involved in this operation are experienced in their work. Most of them were employed during the peak periods of naval hospital activity. In view of the Veterans Administration patient load, the work of this section grows more important since specific information and medical abstracts are required for each veteran patient. (Proposed procedures appear in Appendix I.)

Supernumeraries Desk: The maintenance of separate individual records and reports pertaining to the hospitalization of supernumerary patients is centralized at this desk. Complete admission information, including the Admission Card, all types of identification papers, authority for hospitalization, and letters of request for hospitalization, is routed directly to this desk. The detailed procedures are listed in the recommended procedure appearing in Appendix I.

Veterans Administration Desk: Naval hospitals are required to maintain Veterans Administration patients' records in order to furnish the Veterans Administration with detailed information on all patients admitted and discharged. Complete medical histories are also maintained. Detailed procedures appear in Appendix I.

Present procedures include the necessity for receipt of Authorization for Furnishing Medical or Dental Service, VA-7522, or Admission Card, VA-2557, before Veterans Administration case histories or files may be considered closed. This results in a bottleneck of cases held in a "pending" status. These forms are received, generally, several months after the patient has been admitted to a naval hospital; and in many cases, Veterans Administration patients have already been treated and discharged. In some cases patients have died long before admission authority has been received. Statistics from one hospital in regard to Veterans Administration patients for whom no authorizations were received, are as follows:

1. Number of patients already discharged (June 1946 - February 1947)	224
2. Number of present patients	300
3. Number of deceased patients	<u>100</u>
Total	624

An accredited Veterans Administration representative in either the regional branch office, or the local representative at the hospital can approve the Form P-10, Application for Hospitalization or Domiciliary Care. This approved form should be sufficient certification for the treatment of a Veterans Administration patient. The same form should suffice in the preparation of claims for reimbursement from the Veterans Administration for hospitalization

furnished their patients. Details necessary for obtaining information necessary to supplement authority is a concern of the Veterans Administration, and not the responsibility of a naval hospital.

Recommended Standard Procedures for the Bureau of Medicine and Surgery Section: The "step-by-step" operations for the various desks in the section responsible for preparing required reports and forms for the Bureau of Medicine and Surgery have been studied thoroughly. The composite picture obtained from this study of the methods and procedures, plus the findings and recommendations as discussed in the preceding paragraphs, have been consolidated in a recommended standard procedure. Adoption of these procedures will result in considerable savings in manpower, time, and money. These procedures have been made part of Appendix I in the order in which the various desks are discussed.

#### REPORTS, RECORDS, AND FORMS

Reports, records, and forms compiled or maintained for Bureau statistical purposes in the Bureau of Medicine and Surgery section have been discussed in detail in the foregoing section as a basis for making operational recommendations.

The balance of reports and forms required by the Bureau of Medicine and Surgery are prepared by other sections or desks in the personnel division and are discussed under the appropriate section.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

The majority of personnel assigned to patient records are civilian clerks working on a five-day basis, eight-hours daily, and the routine of the office has been geared accordingly. Enlisted watches, however, are posted to cover specific assignments and emergency matters over the full seven-day period, until 2100 daily. Skeleton crews, assigned over the week-end period, assemble and collect data for subsequent use and completion at the beginning of the week. Only essential daily reports are prepared over the week-end period. No patients are discharged from the hospital on Saturdays or Sundays, if possible.

On the basis of a thorough study of the number of personnel assigned at naval hospitals varying in patient load from 400 to 1250, and a detailed study of operational steps performed by these personnel, certain conclusions are drawn regarding staff requirements for the Bureau of Medicine and Surgery section which are presented in the following table:



# TABLE OF PERSONNEL REQUIREMENTS FOR BUREAU OF MEDICINE AND SURGERY SECTION

	Present Assignments in Hospitals Studied			Recommended, Based on Proposed Procedure		
	400	700	1250	400	700	1250
Patient Loads						
F Card Desk	1C*	1N*	1C	1C	1C	1C
Morbidity Reports Desk	1C	1C	1N	-	1N	1N
Form 10 Desk	1N	3N	1C 1N	1C	1C	1C
Form 36 Desk	1C	1C	1N	-	-	1N
Health Record Custody Desk	1N	1N	1N	-	-	-
Medical Survey Desk	1C	2C	2C 1N	1C	1C	1C 1N
Medical History Write-up Desk	1C 1N	2C	2C 1N	1C 1N	1C 1N	2C 1N
Supermmmeraries Desk	1C	1C	1C	1C	1C	1C
Veterans Administration Desk	1N	(no VAP)	3C 1N	-	1C	2C
Totals	10	12	17	6	8	12

\* Note: C - Civilian Personnel  
N - Naval Enlisted Personnel

Personnel are not provided for desks which can be consolidated, indicated with a dash (-).

The work of the Bureau of Medicine and Surgery section, with group performance competently supervised and through the adoption of the proposed standard procedure, can be accomplished with savings in salaries of from \$10,000 in hospitals with 400 patients to \$12,500 in hospitals with a patient load of 1,250, based on an average annual salary of \$2,500.

## RECOMMENDATIONS

- The following desks, which are concerned primarily with the maintenance of personnel files and records for the completion of forms and reports for the Bureau of Medicine and Surgery, should be located functionally in the Bureau of Medicine and Surgery section:
  - F Card Desk

- b. Morbidity Reports Desk
- c. Form 10 Desk (Daily Personnel)
- d. Form 36 Desk (Ration Record)
- e. Health Record Custody Desk
- f. Medical Survey Desk
- g. Medical History Write-up Desk
- h. Supernumeraries Desk
- i. Veterans Administration Desk

2. Civilians should be assigned to the various desks in the Bureau of Medicine and Surgery Section, and a civilian supervisor should be in charge of the section. Rated corpsmen, however, can perform the duties of the morbidity reports, Form 10, Form 36, and Health Record custody desks, if necessary.
3. Medical officers should be indoctrinated in (1) the proper use of standard Navy diagnostic nomenclature so that clinical forms will be prepared in accordance with prescribed procedures, and (2) the relationship of clinical procedures to record-keeping procedures for better comprehension of naval hospital requirements.
4. The IBM accounting system should be fully utilized to furnish summary morbidity data based on the receipt of current statistics on individual patients, thus eliminating periodic morbidity reports from naval hospitals.
5. Ward nurses should be reminded periodically that accurate and complete ward reports are essential to the successful maintenance of official records.
6. The Ration Record, NAVMED-HF-36, should be reviewed by the Bureau for the possibility of revising the form to simplify and include breakdowns on classifications by groups instead of classifications by individual types.
7. In order to expedite the preparation of the Weekly Report of Patients, NAVMED-I, a daily worksheet should be designed to conform with the classification and columns as shown on the Weekly Report, with one page for seven days' admissions and discharges, and with space provided at the bottom of the page for the weekly summary on Navy and Marine patients.



8. The recommended Health/Service Record receipt or tally card, as shown in Exhibit 24, Appendix II, should be adopted as a standard "NAVMED" form.
9. The Abstract of Antiluetic Treatment, NAVMED-H-7, should be revised to include the branch of service of the patient (e.g., USN, USMC); other personnel, such as dependents, civilian workers, etc.; and race. The form should be prepared in duplicate, with the original forwarded to the Bureau upon completion, and the duplicate retained for the Health Record.
10. The Annual Syphilis Report, NAVMED-A, should be eliminated, since the information required has already been submitted on NAVMED-H-7, and could be tabulated currently for statistical purposes.
11. Interim reports and photostats of clinical records on actively hospitalized Veterans Administration patients should be discontinued since this procedure results in considerable work stoppage, and decreases the efficiency of hospital service. Further, complete clinical histories are eventually furnished the Veterans Administration.
12. Bureau approval of or action on medical surveys submitted by the hospitals should be expedited. At present there is a time lag of three to six weeks.
13. The procedures recommended in Appendix I and the proposed staff requirements for the several desks in the Bureau of Medicine and Surgery Section should be adopted.

## BUREAU OF NAVAL PERSONNEL SECTION

### ORGANIZATION

The Bureau of Naval Personnel section is primarily concerned with the maintenance of personnel files and records for the completion of forms and reports for the Bureau of Naval Personnel. The records contain the current change of duty status on all officer and enlisted patient personnel.

Certain basic "work-groups" in the Bureau of Naval Personnel section are found in naval hospitals regardless of patient loads. They are as follows:

- a. Enlisted Patient Receipt Desk.
- b. Enlisted Patient Transfer Desk (or Duty Party Desk).
- c. Enlisted Patient Discharge Desk.
- d. Officer Patient Desk.
- e. Leave Desk.

The desks concerned with the receipt and transfer of enlisted patients are usually under one supervisor, who is directly responsible to the patient records officer.

### PERSONNEL

At San Diego, military personnel, under the supervision of a chief pharmacist's mate, are utilized for most of the work. Philadelphia uses a majority of civilian clerks, with a civilian supervisor. Since the bulk of work performed in this section does not require a high degree of experience and continuity of service, either military or civilian personnel can be utilized.

### METHODS AND PROCEDURES

Enlisted Patient Receipt Desk: The enlisted patient receipt desk advises the last duty station, and the Bureau of Naval Personnel when a patient is admitted. Basic information is gathered during the patient's hospitalization and filed for ready reference. The pay account is transferred to the disbursing office so that the patient can be paid. If disciplinary action is pending, all necessary information is transferred to the proper authorities in accordance with Navy Regulations.

The Service Record contains personnel data on the entire history of a patient. These records are used by many people for reference or for posting various entries; consequently, the possibility of misplacing or losing this document is considerable. Since replacement



of this document, if lost, is a long, tedious task, the importance of controlling its location cannot be overemphasized.

At present, the hospitals are using a receipt or "tally" card for recording the location of Service Records which are in the custody of the hospital. It is recommended that a standard receipt card be used for all hospitals (Exhibit 24, Appendix II).

The Bureau of Naval Personnel Section uses a Muster Card, NAVPERS-617, to record Navy and Marine enlisted patients for "on-board muster" purposes. The official records received with the patients are entered on these cards, plus subsequent entries of leave dates, etc.

It is proposed that a copy of the standard admission card be used in lieu of the Muster Card, and allowance is made for the inclusion of additional important data.

Enlisted Patient Transfer Desk: The enlisted patient transfer desk is notified when enlisted patients are to be transferred by means of a "Ward Duty" or "Patient's Disposition" memorandum from the ward medical officer. The desk then compiles a list of patients returning to duty, and notifies all interested offices and activities. The initial duty list is prepared in sufficient time to allow for the preparation of orders, and completion of records and check-out of the patient. As a result, the procedure for discharging patients to duty is systematic. (Appendix I)

The district printing offices now furnish local transfer order forms for transferring enlisted personnel. These local forms have proved satisfactory, but the cost of printing them periodically in individual districts is exceedingly high. A Standard Transfer Order, NAVPERS 563/Nav S&A Form 536, was designed in October, 1946, for use by all naval activities. This form is very complete and contains several excellent innovations helpful in records work. Utilization of this form would also eliminate the letter of transmittal covering the local transfer order form.

The following data should be included in space provided on the Standard Transfer Order:

- a. The transfer of personnel and baggage, with a list of the official documents accompanying the patient.
- b. Orders to the disbursing officer to transfer Pay Account (listed on form under "Other Instructions for Disbursing Officer").
- c. The commanding officer's orders to the patient.

- d. A request to the disbursing officer for transportation in connection with official travel.
- e. The transfer date, authority, ultimate destination, duty, authorized delay, travel time, intermediate reportings, and date and time of reporting to ultimate destination.

Identical orders, requests, etc., as listed above, are presently being prepared at all naval hospitals on the following forms:

- a. Transfer of Men, NMSH-Form 3, same as item (a) above.
- b. Orders to Transfer Accounts, NMSH-Form 4, same as item (b) above.
- c. Commanding Officer's Pay Record Order, NAVS&A 510, same as item (b), new transfer form.
- d. Order for Transfer of Men, NMSH-Form 5, same as item (c), new form.
- e. Order for Transportation, NMSH-Form 7, same as item (d), new form.
- f. Transfer Record, NAVPERS-601 page 9Y, same as item (e), new form.

Copies of the Standard Transfer Order are distributed to the same activities now receiving copies of the forms listed in the preceding paragraph. Further, copies of the transfer order are placed in the patients' Service Records. The duplication resulting from the preparation of these various forms could be eliminated by full utilization of the new Standard Transfer Order.

Enlisted Patient Discharge Desk: The enlisted patient discharge desk has cognizance over all patients being discharged from the Navy as a result of medical survey, unsuitability, bad conduct, undesirability, dishonorable discharge, return to terminal leave after being hospitalized during terminal leave, etc. The regular Navy separation process, including civil readjustment, is followed in this procedure. (Appendix I) Applications of patients for the Fleet Reserve are expedited here.

Officer Patient Desk: The officer patient desk maintains officer patient records and prepares all reports and forms for the Bureau of Medicine and Surgery and the Bureau of Naval Personnel. Official documents received with the patient are transmitted to the proper offices, and the orders are endorsed and filed for safekeeping during the patient's hospitalization. Endorsements or orders are prepared at the time of discharge. Periodic fitness reports are prepared and, in case of officers being separated from the Navy, the necessary papers are processed. (Appendix I)



Leave Desk: The leave desk maintains complete file cards on patient and staff leave, and prepares daily lists accounting for personnel in various leave status. These lists are for local use.

There is a problem in accounting accurately for staff and patient personnel going on leave, returning from leave, and being dropped from hospital records at the expiration of terminal leave. Some hospitals have solved this problem by indicating personnel on leave as "inter-ward transfers", between their respective wards or other duty station and the leave desk, on the Ward Report, NAVMED-HF-9. For example, when a patient departs on leave, he is transferred from the ward to the leave desk; upon his return, from the leave desk back to the ward. This procedure eliminates the numerous memoranda usually necessary in "leave" cases plus the pending files or memoranda entries in logs and records.

The leave desk is responsible for full accountability of patient and staff census to the form 10 desk, "F" card desk, information desk, and mail directory service.

Recommended Procedures for the Bureau of Naval Personnel Section: The detailed steps followed by the individual desks in the Bureau of Naval Personnel section were carefully analyzed and studied. The better features of each desk have been incorporated in the proposed procedures (Appendix I). The adoption of these recommended procedures will result in more efficient and economical operations.

#### REPORTS, RECORDS, AND FORMS

The various reports and forms required by the Bureau of Naval Personnel in connection with officer and enlisted patient personnel have been discussed in detail under individual headings or incorporated into the recommended standard procedures. Additional personnel forms and reports required by the Bureau of Naval Personnel and the Bureau of Medicine and Surgery are discussed in the section of the report recommending expansion and further utilization of the personnel accounting system.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

The workload of the Bureau of Naval Personnel section has been adjusted to conform with the five-day week schedule of civilian personnel. With the exception of certain operational steps which require daily attention over a seven-day period, such as the functions of the enlisted patient receipt desk, this section accomplishes its work on a five-day week basis. No patients are sent to duty between Friday and Monday, and in some cases not until Tuesday.

Naval personnel on week-end watches handle all emergency items which require immediate attention. The bulk of the reports are prepared during the regular five-day week.

Detailed information was obtained on the number of personnel assigned to the various desks in the Bureau of Naval Personnel section and their duties. These data are tabulated for comparison purposes in three groups, showing assignments at hospitals with patient loads of 400, 700, and 1250. The personnel requirements, recommended below, are based on an analysis of current operations plus the proposed procedural changes.

#### PERSONNEL REQUIREMENTS FOR BUREAU OF NAVAL PERSONNEL SECTION

Patient Loads:	Presently Assigned (In hospitals studied)			Recommended (Based on proposed procedure)		
	400	700	1250	400	700	1250
Enl. Pat. Receipt Desk	1N	1C 1N	1C 1N	1N	1N	1C 1N
Enl. Pat. Transfer Desk	1C	1C 1N	3C 3N	1C	1C 1N	1C 1N
Enl. Pat. Discharge Desk	1N	1C 1N	1C 1N	-	1C	1C
Officer Patient Desk	1C	1C	1C 1N	1C	1C	1C
Leave Desk		1N	1N	1N	1N	1N
Total	4	8	13	4	6	7

C - Civilian Personnel      N - Naval Enlisted Personnel

The adoption of the recommended procedures for the work in this section will result in savings in personnel salaries of from \$5,000 in a medium size hospital to \$15,000 in a large hospital, based on an annual average salary of \$2,500.

#### RECOMMENDATIONS

1. The following desks, which are concerned primarily with the maintenance of personnel files and records for the completion of forms and reports for the Bureau of Naval Personnel, should be located functionally in the Bureau of Naval Personnel Section:
  - a. Enlisted Patient Receipt Desk
  - b. Enlisted Patient Transfer Desk
  - c. Enlisted Patient Discharge Desk



d. Officer Patient Desk

e. Leave Desk

Either military or civilian personnel can be utilized in this section.

2. The Health/Service Record Receipt Card (Exhibit 24), should be adopted as a standard form for controlling the location of Health and Service Records within the hospital. All existing local tally forms should be eliminated.
3. Upon acceptance of the proposed standard Admission Card, the Muster Card, NAVPERS-617, should be eliminated.
4. All naval hospitals should use the new Standard Transfer Order, NAVPERS-563/NAVS&A Form 536, and discontinue the use of all local transfer order forms.
5. The Medical Department forms, NMSH-Forms 3, 4, 5, and 7, should be eliminated, since identical information can be furnished on the Standard Transfer Order.
6. The Bureau of Supplies and Accounts and the Bureau of Naval Personnel should be contacted regarding the necessity for their respective forms NAVS&A-510 and NAVPERS-601 (page 9Y) in view of their duplication with the Standard Transfer Order, which is a joint NAVPERS-NAVS&A form.
7. Information on the use of the NAVMED-HF-9, Ward Report, for personnel in a leave status, should be disseminated among various naval hospitals.
8. Personnel who go on leave should be indicated on the Ward Report, NAVMED-HF-9, as "inter-ward transfers", between their respective wards or other duty station and the leave desk. Upon their return from leave they should be transferred back from the leave desk to their respective wards or other duty station.
9. The procedures recommended in Appendix I and the proposed staff requirements for the several desks in the Bureau of Naval Personnel Section should be adopted.

## PERSONNEL ACCOUNTING DESK

### ORGANIZATION

The personnel accounting desk is responsible for furnishing information on naval personnel to the Bureau of Naval Personnel in accordance with the prescribed standard procedure. Since most personnel information concerns patients, this activity is usually located in the patient records office. Personnel who prepare similar information for staff personnel are under the cognizance of the military personnel officer. Liaison is maintained between the two offices in order to complete the daily report successfully.

### PERSONNEL

The Navy Personnel Accounting System has been in effect in naval hospitals since September, 1946. Personnel engaged in the work are still undergoing indoctrination in the mechanics of the procedure. Chief pharmacist's mates or pharmacist's mates, first class, who are assigned to these sections are handling the work capably and show considerable interest in and enthusiasm for the system. A system of replacement training should be established in view of personnel turnover, and since, in many cases, the thorough experience being gained by the individual maintaining the accounting files is rendering him indispensable.

### METHODS AND PROCEDURES

Only that portion of the personnel accounting procedure affecting the flow of forms among the various units within the hospital was studied. This approach was followed because the mechanics of the procedure are described fully in the Bureau of Naval Personnel's pamphlet on the Navy Personnel Accounting Procedure.

The survey team studied the possibility of more extensive use of the personnel accounting system as applied to naval hospitals. The machine-accounting system is sufficiently flexible to provide personnel tabulations of almost any type, and therefore can eliminate many reports. An analysis of numerous other personnel reports required by various bureaus in the Navy indicates that all required compilations could be combined, condensed and submitted for tabulation by accounting machines.

Personnel forms and reports prepared for the Bureau of Naval Personnel are forwarded daily to the respective naval district personnel accounting offices in accordance with



personnel accounting procedures prescribed by the Bureau of Naval Personnel. This system provides for the recording of personnel data on accounting machines geared to tabulate the data in prescribed coded form.

Discussions with various district personnel accounting officers and with the officer who has cognizance of the personnel accounting system at the Bureau of Naval Personnel revealed that the possibilities of code variations are unlimited. They would provide for the tabulation of any additional, specific data peculiar to hospital personnel, both staff and patient. From this information it is assumed that personnel data presently being furnished the Bureau of Medicine and Surgery could be combined with the data furnished the Bureau of Naval Personnel. The data could be compiled through predetermined methods by the district personnel accounting machines, and the completed tabulations furnished the Bureau of Medicine and Surgery whenever and in whatever form is desirable. The separate preparation of personnel forms and reports would be eliminated by the use of machine accounting, thus saving considerable time and manpower for the Bureau.

In the following portions of the report each current personnel form and report is summarized to illustrate the existing duplication. The compilation of necessary data for the forms and reports is accomplished presently through the use of Navy indexes and worksheets.

Personnel Accounting Card, NAVPERS-500: This form is prepared for and accompanies all naval personnel reporting to a hospital for duty or treatment, undergoing a change of status while hospitalized, or being detached from duty or hospitalization. It provides numbered "blocks" for machine tabulation purposes, in which are entered historical and operational data in accordance with procedures outlined by the Bureau of Naval Personnel. The information on this card is similar to that required by the Bureau of Medicine and Surgery on the Receipt, Transfer, and Status Card, NAVMED-HC-3, for Hospital Corps personnel, with the following exceptions:

- a. Name of next of kin of staff or patient Hospital Corps officer or enlisted man.
- b. Permanent address.
- c. Place of birth.
- d. Rate and class of enlistment (new personnel).

Daily Personnel Diary, NAVPERS-501: This report is prepared from personnel accounting cards and is a summary of all daily changes concerning patients and staff, officer and enlisted. Certified copies of the Daily Personnel Diary, together with copies of the Personnel Accounting Card, NAVPERS-500, are forwarded to naval district personnel accounting offices where machine tabulations are run in a prescribed manner. Each month, a chronological diary of daily changes is forwarded to the Bureau of Naval Personnel. The district personnel accounting office is equipped to furnish data on naval hospital personnel in any form and at any time.

Roster of Officers, NAVPERS-353: Although a portion of this roster is already included in the NAVPERS-500 and 501 reports, certain additional operational data ("Collateral Duties", "Duties in Training Form", etc.) are required for the information of the Bureau of Naval Personnel. The Personnel Accounting Office of the Bureau of Naval Personnel is currently studying the possibility of coding this information and including it on the NAVPERS-500 and 501. Until the personnel accounting procedures are revised, the Roster of Officers must be considered as required from naval hospitals.

#### BUREAU OF MEDICINE AND SURGERY FORMS AND REPORTS

Receipt, Transfer, and Status Card, NAVMED-HC-3: This form, prepared for each change in status of patient and staff Hospital Corps personnel, and forwarded daily to the Bureau of Medicine and Surgery, contains much data identical to that in the Daily Personnel Diary, NAVPERS-501. The few exceptions are items such as name of next of kin, permanent address, place of birth, etc., which could be readily absorbed into the machine personnel accounting system. (See paragraph on "Personnel Accounting Card, NAVPERS-500" above.)

Roster Report of the Hospital Corps, NAVMED-HC-4: This report is a monthly summarization of changes in status in Hospital Corps personnel as reflected in the NAVMED-HC-3 forms prepared during the month. Again, this is information included in the Daily Personnel Diary. An additional item required on this report under the "Remarks" column concerns the patient's diagnosis and probable date of discharge. This information is furnished the Bureau in the form of the "Fa" Card, Individual Statistics on Patients.

Admission or Discharge of Officer, NAVMED-HF-1: This form is completed and forwarded upon the admission or discharge of Navy and Marine Corps officers when the officer reports in compliance with written orders or when his estimated length of hospitalization is seven days or over. Identical information is submitted daily on the Daily Personnel Diary, with the



exception of diagnosis information, which is submitted to the Bureau of Medicine and Surgery on the "Fa" card. In addition, copies of orders, with all endorsements, of officers reporting at activities must be forwarded to the Bureau of Naval Personnel, to furnish operational data in still another form. Marine Corps officers admitted or discharged may still require the NAVMED-HF-1 form, since the Daily Personnel Diary does not include personnel data on Marine Corps personnel. However, the copies of the officers' orders might suffice.

Roster Report of the Medical Corps, NAVMED-953: This monthly report, which applies specifically to Marine Corps personnel, includes the same data that is submitted on the Daily Personnel Diary to the Bureau of Naval Personnel, and the diagnosis information furnished the Bureau of Medicine and Surgery on the "Fa" card.

Hospital Bed Capacity Report, NAVMED-103: This report is prepared quarterly, showing the authorized and practical bed capacities, available beds in use and storage, and the assignment of beds to patient and staff personnel. The bed capacity report also contains information similar to that in the Weekly Report of Assignment and Housing of Hospital Corps Personnel (see next paragraph).

Weekly Report of Assignment and Housing of Hospital Corps Personnel: This report, in letter form, gives a breakdown of the duty assignments and beds assigned Hospital Corps personnel. Since demobilization is now completed, and critical housing shortages for naval personnel do not exist, this report does not appear essential. The quarterly Hospital Bed Capacity Report furnishes adequate housing information, and the assignment of Hospital Corps personnel is covered in the Daily Personnel Diary.

Weekly Report of Enlisted Hospital Corps USN/USNR on Board for Duty and Instruction: This letter report is prepared weekly from the index files on Hospital Corps enlisted personnel, separated into specific categories according to rate. In addition to this report, a similar one, compiled in more detail, is prepared for the district medical office. The district medical office combines this report with those from other activities and submits the Combined Report of Enlisted Hospital Corps, NAVMED-590, to the Bureau. The statistics in both reports duplicate information submitted in the Daily Personnel Diary.

Recommended Standard Personnel Accounting Desk Procedures: In summary, naval hospitals are furnishing personnel reports which are, in large measure, identical to the Bureau of Naval Personnel and the Bureau of Medicine and Surgery. One of these reports, the Daily Personnel

Diary, NAVPERS-501, involves the utilization of a machine accounting system which is flexible enough to absorb the data submitted on certain other forms, thereby providing for the elimination of these forms. The foregoing analysis of the essentiality and usefulness of personnel reports also indicates that several of them are obsolete and therefore unnecessary.

The proposed standard procedure for implementing the personnel accounting system in naval hospitals (Appendix I) is based on the findings and conclusions discussed in this section of the report.

#### REPORTS, RECORDS AND FORMS

With the exception of a copy of the Admission Card properly noted as to the disposition of patients in order to close out the personnel accounting cards, no additional forms or reports are necessary to accomplish the functions of this unit. Kardex files, as recommended in the standard Navy personnel accounting procedure, are highly satisfactory and adequate in the maintenance of indexes.

#### STAFF REQUIREMENTS

One clerk should be assigned to the personnel accounting desk in small to medium hospitals, and one petty officer plus an assistant in medium to large hospitals.

#### RECOMMENDATIONS

1. A joint study should be initiated by the Bureau of Medicine and Surgery and the Bureau of Naval Personnel immediately to explore the possibilities of utilizing the Naval Personnel Accounting System for the tabulation of personnel data presently being furnished the Bureau of Medicine and Surgery in a series of several reports.
2. The following reports and forms, which are submitted to the Bureau, should be eliminated upon revision of the personnel accounting procedures to include the additional information required:
  - a. Receipt, Transfer, and Status Card, NAVMED-HC-3.
  - b. Roster Report of the Hospital Corps, NAVMED-HC-4.
  - c. Admission or Discharge of Officer, NAVMED-HF-1.
  - d. Roster Report of the Medical Corps, NAVMED-953.
  - e. Weekly Report of Assignment and Housing of Hospital Corps Personnel (letter report).
  - f. Weekly Report of Enlisted Hospital Corps USN/USNR On Board for Duty and Instruction (letter report).



3. The letter report, Weekly Report of Assignment and Housing of Hospital Corps Personnel, should be eliminated. Now that demobilization has been completed, the data furnished in the quarterly Hospital Bed Capacity Report, NAVMED-103, are sufficient. Information regarding assignments could be submitted on other personnel accounting forms and reports.
4. A system of replacement training for work on the personnel accounting desk should be established in view of personnel turnover and since, in many cases, the thorough experience being gained by the individual maintaining the accounting files is rendering him indispensable.
5. One clerk, either a chief pharmacist's mate or pharmacist's mate, first class, should be assigned to the personnel accounting desk in small to medium hospitals, and one chief plus an assistant in medium to large hospitals.
6. The standard procedure for the personnel accounting desk, as proposed in Appendix I, should be adopted.

## CARE OF THE DEAD DESK

### ORGANIZATION

The care of the dead desk is under the cognizance of the patient records office. Close liaison is maintained with the officer of the day, whose duties are closely connected with several features of the care of the dead procedure.

The functions of the care of the dead desk or "Deaths Desk" are:

- a. To prepare all forms and reports on deceased patients.
- b. To maintain pertinent records.
- c. To expedite the disposition of the remains.

At several hospitals this desk is physically located in the middle of a noisy and busy office, which is an extremely poor location for this type of activity. No attempt was made to offer privacy or quiet surroundings for the next of kin during interviews, and the curiosity of the office personnel at adjacent desks was noticeable. Hospitals with a high mortality rate in particular, should conduct interviews with next of kin in private rooms.

### PERSONNEL

A civilian clerk generally is responsible for this desk. Middle-aged personnel are usually most satisfactory in this job, since they are more likely to have the tact and understanding essential in dealing with next of kin. Capable clerks are also instrumental in obtaining permission for post-mortem examinations from the next of kin of deceased Veterans Administration patients. These examinations afford pathological studies which are very desirable from the medical point of view. In large hospitals the detailing of a corpsman assistant to prepare daily serious and critical lists is highly satisfactory.

### METHODS AND PROCEDURES

The voluminous details and numerous operational steps incidental to the death of a patient have resulted in an involved procedure. The essentiality of each detail and the effectiveness of the entire procedure were carefully analyzed. Several variations in procedure exist, particularly in regard to deceased Veterans Administration patients. A proposed standard procedure for care of the dead routine for Navy, Marine and Veterans Administration personnel is outlined in detail in Appendix I. The Navy and Marine procedures also include all steps required for supernumerary and dependent deaths..



Many functions are performed relative to handling of deceased Veterans Administration patients which according to directives, are the responsibility of the Veterans Administration. Paragraph 3417.8 of the Manual of the Medical Department prescribes that a standard dispatch be sent to the next of kin of deceased Veterans Administration patients, which states, in part, "Additional information will be sent to you by the regional manager, Veterans Administration, with whom all arrangements for disposition should be made". Further, paragraph 3442.6 of the Manual states, "The remains of Veterans Administration patients who die in a naval hospital shall be transferred to the custody of the Veterans Administration regional director who will assume full charge of all arrangements for the preparation and disposition of the remains." The hospitals are not following the Manual, but are requesting immediate advice from the next of kin for the disposition of remains, thereby soliciting additional responsibilities without proper authority.

As an additional service, some hospitals are completing certain Veterans Administration forms, most of which request information already furnished on the state death certificates and the Certificate of Death, NAVMED-N. In cases of deceased Veterans Administration patients, the obligation of the Navy is discharged upon completion of the following:

- a. Notifying the next of kin at the time of death, as directed by Paragraph 3417.8 of the Manual of the Medical Department.
- b. Filling out the state death certificate.
- c. Filling out the Certificate of Death, NAVMED-N.
- d. Inventorying the personal effects and delivering them to the Veterans Administration.
- e. Inspecting and approving the condition of the remains (by the medical officer of the day) prior to their transfer to a representative of the regional director of the Veterans Administration.

The serious and critical list procedures are almost identical in each hospital. The ward medical officer or ward nurse notifies the records clerk of changes in the serious and critical list of the previous day so that a new daily list can be prepared for distribution. This list may be either typed or stencilled, depending on local needs. The preparation of the daily serious and critical list has been recommended as a collateral duty of this desk. The procedure for this function is extremely simple, and does not require the services of a full-time clerk.

Recommended Standard Care of the Dead Procedure: The responsibilities of the Navy regarding Veterans Administration deceased personnel, which are spelled out in the Manual of the Medical Department, have been taken into consideration in the proposed standard procedure for the care of the dead desk. This procedure and that for the serious and critical list are outlined in detail in Appendix I. The adoption of these procedures will result in the reduction of an appreciable amount of work.

#### STAFF REQUIREMENTS

In hospitals where there are no Veterans Administration patients, and consequently fewer cases of deaths, the work of this desk is very light and is usually a collateral duty of some other desk or unit. For hospitals with a patient load of 400, one civilian clerk can handle the workload. For hospitals with patient loads of 700 to 1250 one civilian clerk and one assistant (a corpsman or civilian clerk) will be sufficient.

#### RECOMMENDATIONS

1. A private room or enclosed space, rather than a desk in a noisy and busy office, should be provided for interviews with next of kin.
2. A civilian clerk who has the tact and understanding necessary to deal with next of kin should be assigned to the care of the dead desk.
3. Naval hospitals and Veterans Administration regional offices should clarify their respective responsibilities in connection with serious and critical list patients and the disposition of deceased Veterans Administration patients. At present the hospitals are performing many services in connection with deceased Veterans Administration patients which should be handled by the Veterans Administration.
4. The practice of preparing Veterans Administration reports and forms for the convenience of the Veterans Administration regional offices should be discontinued.
5. The file cards prepared on individual patients who are placed on the serious and critical list are not necessary and should be eliminated, since the ward memoranda and the serious and critical list for the previous day provide sufficient information.
6. The standard procedure for the care of the dead desk, which also includes the serious and critical list, as proposed in Appendix I, should be adopted.



## MILITARY PERSONNEL SECTION

### ORGANIZATION

The military personnel section is under the cognizance of the personnel division and is responsible for receiving, detailing, transferring, and discharging enlisted personnel, handling reenlistments, and maintaining staff personnel records. Close liaison is maintained with the patient records office to expedite and coordinate the work of both activities.

### PERSONNEL

The work of this section can be performed by either civilian or military personnel, since continuity of service is not essential for the specialized experience involved in the duties of the various desks. A chief petty officer, however, is preferred for duties at the detail desk, since this position provides valuable training for Hospital Corps career personnel.

### METHODS AND PROCEDURES

The procedures for the military personnel section, particularly concerning the maintenance of current staff personnel records, are a series of operational steps necessary to prepare personnel forms, reports, and memoranda for the local command, the Bureau of Medicine and Surgery, and the Bureau of Naval Personnel.

The following functional desks are located in this section:

- a. HC-3 and HC-4 Desk
- b. Enlisted Detail Desk
- c. Enlisted Receipt, Transfer, Discharge, and Reenlistment Desk
- d. Staff Officer Desk

HC-3 and HC-4 Desk: The HC-3 and HC-4 desk accounts for all changes in status of Hospital Corps personnel in order to complete the necessary forms and reports for the Bureau of Medicine and Surgery. The proposed standard procedures in Appendix I include the HC-3 and HC-4 reports, although recommendations have been made for their elimination provided the Bureau of Medicine and Surgery and the Bureau of Naval Personnel personnel reporting procedures can be combined. Until a definite decision is made regarding the revision of the personnel reports procedure, a standardized procedure for the HC-3 and HC-4 reports should be installed.

Detail Desk: The daily assignment of enlisted personnel, and the maintenance of an up-to-date record of these assignments are the responsibility of the detail desk. This clerk should furnish data on assignments of personnel to the finance division for the preparation of the Expense Analysis Register. The working steps include the utilization of a system of file indexes, divided into separate categories, i.e., alphabetically, by assigned detail, and by

technical qualification. (For the patient rehabilitation phase of detailing see the "Rehabilitation Service" section of the report.)

Receipt, Transfer, Discharge and Reenlistment Desk: This desk is responsible for the preparation of forms, reports, endorsements of orders, etc., for the Bureau of Naval Personnel on personnel received for duty, transferred to another activity, discharged from the service, or reenlisting.

Staff Officer Desk: The staff officer desk prepares all forms, reports, and endorsements for staff officers undergoing any change in status.

Proposed Standard Procedures: The majority of the reports, letters, and forms prepared in the military personnel section are required by the Bureau of Medicine and Surgery. These reports have been included under the specific desks in the operational steps comprising the recommended standard procedures (Appendix I). Several of the reports prepared for officers, and those prepared for enlisted personnel, are discussed under "personnel accounting procedures" in the portion of the report on the patient records office. Many of these reports could be eliminated or consolidated under the Bureau of Naval Personnel personnel accounting system. In the meantime, however, it is recommended that naval hospitals employ a uniform method of preparing and processing all reports currently in use.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

The uniformity of personnel procedures allows for a constant workload which can be handled with few people. The following table shows the personnel presently assigned to the military personnel section, and the complement recommended as a result of the survey.



TABLE OF PERSONNEL REQUIREMENTS FOR MILITARY PERSONNEL SECTION

Patient Load:	Presently Assigned in Hospitals Studied			Recommended (Based on Proposed Procedures)		
	400	700	1250	400	700	1250
HC-3 and HC-4 Desk	2N	2N	1N	1N	1N	2N
Enlisted Detail Desk	1N	3N	1N	1N	2N	4N
Enlisted Receipt, Transfer, Discharge and Reenlistment Desk	1N	( 1C 1N	3N	1N	1N	2N
Staff Officer Desk	1C	1C	1C	-	{ 1C	{ 1C
Staff Reports and Letters	1C	1C	1N	-	{ -	{ -
TOTALS	6	9	7	3	5	9

C - Civilian personnel  
N - Naval enlisted personnel

If these recommendations regarding the assignment and utilization of personnel are adopted, the military personnel section can be operated with a yearly savings in salaries ranging from \$5,000 to \$7,500 per hospital, based on an average annual salary of \$2,500.

#### RECOMMENDATIONS

1. Assignment of patients to work details should be the responsibility of the military personnel section.
2. The military personnel section (detail desk) should be responsible for furnishing personnel data to the finance division as the basis for completing the "military pay" section of the Expense Analysis Register.
3. The following desks should be located in the military personnel section:
  - a. HC-3 and HC-4 Desk
  - b. Enlisted Detail Desk
  - c. Enlisted Receipt, Transfer, Discharge, and Reenlistment Desk
  - d. Staff Officer Desk

Either civilian or enlisted personnel can perform these duties, although a chief pharmacist's mate is preferable for the detail desk.

4. Many of these reports could be eliminated or consolidated under the Bureau of Naval Personnel personnel accounting system. Until such time as a definite decision is made regarding the revision of the personnel reporting procedures, however, naval hospitals should employ a uniform method of preparing and processing all reports currently in use. The standard procedure for the military personnel section proposed in Appendix I, therefore, should be adopted.
5. The organizational nomenclature used on the "HC-4" concerning the assignment of military personnel should be standardized.
6. The recommended complement for the military personnel section, by individual desks, should be adopted.



## BAG ROOM

### ORGANIZATION

The bag room is responsible for the custody of patients' personal effects and baggage. Adequate areas with sufficient storage-bin space are provided for the storage of patients' baggage. These areas have been designated as "restricted", and are well-guarded against fire and entry by unauthorized personnel. One generally unavoidable feature is the location of bag rooms in outlying sections of the hospital compound which makes it necessary to transport baggage from the admission unit. The ideal location for bag rooms would be in spaces immediately adjacent to the admission units for the convenient stowage of personal baggage upon the admission of patients.

All patients, except Navy and Marine personnel, are advised not to enter a hospital with large quantities of personal effects. Consequently, no storage problems exist regarding supernumerary patients.

Responsibility for Bag Room: The provost marshal (security officer) is charged, occasionally, with responsibility for bag room functions because of the security involved. In most cases, responsibility for the bag room is not definitely established, although the admission unit and bag room are closely related. The proper functioning of the bag room is clearly a responsibility of the patient records officer since he is immediately responsible for safekeeping patients' personal effects through the recording and acceptance of baggage. The records officer also assumes responsibility for subsequent additions or withdrawals from personal effects, as reflected in the patients' records. At the time of discharge, the records officer is accountable to the patient for the return of all personal effects, and would be responsible for action on claims against the Navy for lost, stolen or damaged gear.

### PERSONNEL

The assignment of corpsmen to the bag room detail, especially in hospitals with many temporary outbuildings, is highly recommended since they serve a dual purpose. In addition to performing clerical duties, the corpsmen are utilized on "fire" watches, thus adding considerably to the hospital safety program. The assignment of a chief pharmacist's mate or senior petty officer as bag room supervisor is warranted by the constant turnover of valuable clothing and effects, and the presence of a large number of military personnel claiming personal effects at various times. The present surplus of chief petty officers allows for this provision.

## METHODS AND PROCEDURES

Forwarding Unclaimed Baggage to Disposal Centers: Large quantities of unclaimed baggage remain at naval hospitals due to the huge patient turnover during and immediately after the war, inefficient record-keeping, improper tagging of personal effects of patients, and general laxity in the proper "check-out" of patients. This creates a major baggage disposal problem. One hospital has 1,000 pieces of unclaimed baggage in addition to current baggage. Considerable correspondence in regard to this baggage is necessary with disposal centers and discharged personnel, most of whom have been demobilized. In addition, forwarding addressees in many cases are inadequate. Through adoption of the recommended bag room procedure, no problem should exist after disposal of the accumulated unclaimed baggage.

Bag Room Forms: In many instances there is no provision on standard forms for the service numbers of Navy and Marine personnel, thereby making it difficult to identify personal effects in cases where similarity in names, illegible handwriting, etc., exist. Further, certain nomenclature on the forms is obsolete, such as the item "hammock number", which necessitates the rewriting of nomenclature on the forms. The adoption of a standard current form with an added space for a serial number would facilitate bag room operations.

Proposed Standard Bag Room Procedure: A standard bag room procedure is recommended for adoption (Appendix I). All the changes and recommendations are incorporated which are discussed in this section and the admission section (regarding the application of metal seals) and the better features of several existing bag room procedures are incorporated in the proposed standard procedure.

## WORK MEASUREMENT AND STAFF REQUIREMENTS

Bag rooms are open at specific hours, on certain days of the week, for the deposit or withdrawal of personal effects. Baggage is received and issued daily except Sunday for admissions and discharges. No delay is caused in issuing baggage if duty party lists are received 24 hours in advance of a patient's discharge. In most cases personnel are not discharged on Saturdays and Sundays, which allows ample time to maintain cleanliness in the bag room area and provide for the proper stowage of baggage. One chief pharmacist's mate and two corpsmen can handle a daily average of 40 to 50 pieces of baggage, including those for patients being admitted and patients being discharge. Night watches are handled by corpsmen on either the port or starboard watch, since someone must be present at all times on the premises.



#### RECOMMENDATIONS

1. The records officer should be charged with responsibility for bag room activities, including the record-keeping function and the supervision of bag room personnel.
2. Hospital corpsmen should be assigned to the bag room detail. A staff of one chief pharmacist's mate and two corpsmen can handle an average of 40 to 50 pieces of baggage daily.
3. All unclaimed baggage should be prepared immediately for shipment to official baggage disposal centers.
4. The following form revisions should be considered by the Bureau:
  - a. File/Serial No. should be added to the NAVMED-G, Hospital Ticket, and NAVMED-416, Hospital Ticket-Women.
  - b. "Hammock No." should be changed to "Handbag No." and "File/Serial No." added on both portions of perforated form NAVMED-HF-22, Personal Effects Tag. (Exhibit 25, Appendix II.)
5. Upon the adoption of the proposed bag room procedure, all local forms and supplementary logs and records being used presently should be eliminated.

## MISCELLANEOUS SERVICES

### INFORMATION DESK

The information desk is generally a part of, or located immediately adjacent to, the office of the officer of the day. Ideally, this desk should also be in close proximity to the records office. All personnel engaged in information desk activities are under the direct supervision of the officer of the day, but assigned by the personnel officer.

A master locator file for information purposes is provided by maintaining a visible card index of copies of the Admission Card. Inter-ward transfers, as well as daily changes in admissions, discharges, deaths, etc. are recorded in this file. Colored tabs provide ready reference regarding critically and seriously ill patients. Similar devices provide information on patients on leave, including the time of departure and the expected time of return.

A separate portion of the visible index including information concerning staff officers, their current location and any changes in assignments, is recorded in a separate section of the visible index. In one hospital, "flash-call" numbers are assigned to staff officers which provide a system of contacting officers in any part of the main hospital building via an electrically controlled switchboard located at the information desk.

The officer of the day notifies the information desk of all deaths occurring in the hospital, at which time the appropriate card is removed and the death noted. This becomes a record to establish the exact time of death for vital statistics reports prepared in the records office.

The Proposed Procedures for the Information Desk, which follow, are for the guidance of the clerk responsible for the master locator index file.

### PROPOSED INFORMATION DESK PROCEDURE

1. Each morning information clerk receives #2 copy of Admission Card from the admission unit on all patients, including dependents, admitted through 2400 on the previous day, (If unusually large number of admissions are received through 1600 the previous day, the #2 copy is taken to the information desk at that time.)
2. Clerk files Admission Card alphabetically in master locator index, regardless of category of patient.
3. Receives inter-ward transfer slips each morning showing transfers of patients from ward to leave desk (AOW) and from leave desk to ward (TOW). Posts to master locator index.
4. Receives copy of Ward Report each morning from leave desk, listing patients "to leave" and "from leave". Posts leave information to master locator index. The use of a colored plastic tab to denote patients on leave is recommended for ready reference purposes.



5. Receives copy of Form 10 each morning. Checks admissions against all #2 copies of admission cards received that morning. Pulls admission cards on discharges. Notes disposition, date and authority on cards, and files cards alphabetically in inactive file.
6. Receives file cards from the staff officer desk on all staff officers reporting for duty. Assignment is previously entered on card by records office clerk. Files this card in a separate section in the master locator index, and maintains card currently as changes in assignments occur.

Serious and Critical List Procedure as it relates to the Information Desk: The information desk clerk receives a copy of memorandum, usually a local form, placing patients on or removing them from the serious or critical list. (Officer of the day has previously received this information from the ward medical officer.) Clerk posts information to the master locator index. Colored plastic tabs may be used to denote patients on the critical or serious list for ready reference purposes.

Deaths: Officer of the day notifies information desk regarding death of patient. Information clerk pulls master locator card, notes data, and files card in inactive file.

#### MAIL DIRECTORY SERVICE (MAIL ROOM)

The mail directory service was instituted during the war when the volume of incoming personal mail increased as the patient load increased, and, together with the rapid turnover of patients, made constant directory service necessary. Since the prompt receipt of personal mail is an important morale factor, efficient directory service continues to be very important.

Separate Kardexes are maintained on all patients, staff personnel, Red Cross employees, Veterans Administration representatives, and other personnel in the hospital. A maximum of two files is recommended, one for patients and the other for staff personnel. A copy of the Admission Card, the daily personnel report, and other memoranda from the administrative office provide information for the location of personnel. Arrangements exist with postal authorities for the receipt of "pre-packaged" bundles of letters to facilitate the rapid delivery of mail which has been properly addressed with ward numbers, etc. The Kardex files provide rapid directory service for deliveries which require additional forwarding information.

A patient reports to the mail directory service as part of the "check-out" process, and leaves his forwarding address with the mail directory clerk. The daily personnel report or "change of address" card furnishes the same information on other dispositions. All changes are noted in the Kardex.

## CENTRAL (CORRESPONDENCE) FILES UNIT

The filing and control of a patient's Clinical Chart is one of the major responsibilities of the correspondence files unit. Normally, this unit is located adjacent to the records office, since constant reference to the patient's jacket is necessary. The patient's jacket, a large manila envelope into which the chart is eventually inserted, is prepared upon admission of the patient and is immediately sent to central files for alphabetical filing. It remains here during the period of the patient's hospitalization.

At the time of the patient's disposition, the Clinical Chart and a copy of the Admission Card, showing the disposition, date, and authority are received by central files. The chart and Admission Card are inserted in the jacket, and a copy of the Admission Card is filed alphabetically for cross-reference purposes. The patient's jacket is removed from the alphabetical file and refiled according to hospital register number. This file on discharged patients is maintained in central files for a two-year period, and is then forwarded to a records disposal center.

The personnel at most of the hospitals studied are still engaged in clearing, sorting and packaging the large quantities of records accumulated from the demobilization period when patient loads were high and turnover was rapid.

Processing of Mail: All processing of incoming and outgoing correspondence, including the receipt and transmittal of official documents pertaining to admission of patients, is usually handled in this unit. Incoming mail is picked up several times daily from the post office and distributed. The clerk opens, screens, and sorts routine mail, and forwards important mail to the administrative officer for action.

Most administrative officers devote a great portion of their time, unnecessarily, to duties normally required of good correspondence file clerks in the detailed opening, sorting, and screening of official correspondence. Since most hospitals are adhering to the standard Navy filing manual index, it should be a relatively simple matter for civilian or military file clerks to prepare this correspondence for action. All necessary reference material should be attached to the correspondence by the file clerk and routed to the proper desk for action.





## FINANCE DIVISION

Many of the fiscal operations performed in naval hospitals are prescribed by accounting instructions issued by the Bureau. These instructions were being revised during the survey. Since the survey team did not know to what extent the new instructions would affect present work methods, it did not consider that a detailed analysis of this part of the hospital organization at this time would be practical. However, since finance is one of the largest administrative divisions, it was reviewed in accordance with the overall objectives of the survey project.

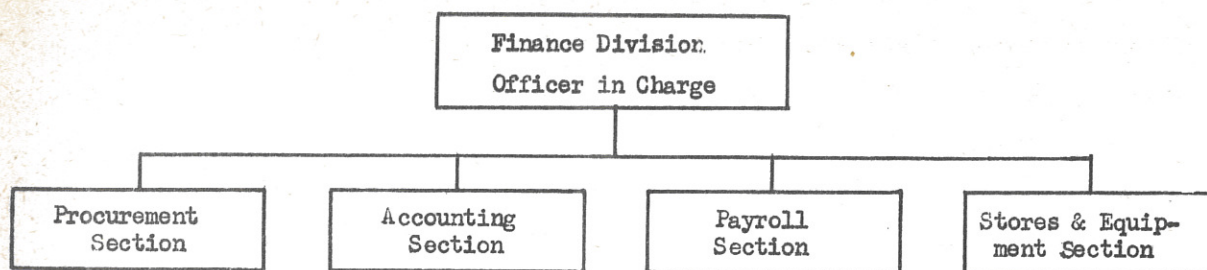
From discussions with finance division personnel and a review of operating methods, it is very apparent that some procedures are unnecessarily complex, and too much time and effort are spent on work of questionable value in maintaining fiscal controls. The organization of some finance divisions is uneconomical, and overstaffing is obvious. The rapid conversion from a wartime to a peacetime status presented many problems, but it is difficult to justify the continued existence of certain practices which should be corrected in order to eliminate the presence of a top-heavy financial organization in hospital establishments.

### ORGANIZATION

With one variation, the functions performed by finance are the same in all the hospitals. *With the exception of San Diego and Newport*  
~~At San Diego~~ the finance division continues to direct the civilian personnel program. Since the functions are similar, it is natural to assume that the organizational structure of the several finance divisions, especially in hospitals of similar size, should vary only slightly. On the contrary, however, it was found that the finance division of each hospital is organized quite differently. It appears that each new finance officer introduces changes to conform with his previous experience or personal desires. Instances of both under and over-organization exist. In one large hospital there is no well-defined pattern, the finance officer being directly in charge of practically each desk. At a smaller command there are too many organizational units with very little control exercised by the officer in charge over the personnel performing the work. No two finance divisions have approximately the same number of sections or any uniform method of designating them. With these conditions prevailing, the reason for the differences in internal organization is understandable. In the interest of general economy and efficiency, the organizational structure should be practically the same at each hospital with more than 400 patients. As the size of the hospital decreases, the reductions in personnel should not alter the organizational structure. The following general organizational pattern should be used by the Bureau of Medicine and Surgery as a guide in developing standard



finance organizations for naval hospitals.



#### PERSONNEL

Training and Assignment of Finance Officers: The finance officer has supervision of as difficult and complex a job as any hospital division chief. Officers assigned to this position should have considerable training and experience, if satisfactory performance is to be expected. It is not a position which can be filled by an officer who has practically no academic training in accounting, or who has not had actual experience in some of the more responsible jobs in finance. Several finance officers stated that they did not have sufficient training in accounting to perform the work most effectively. Officers selected for fiscal assignments should be adequately trained in this type of work, and those who do specialize in finance should be retained on these functions and not rotated to other types of administrative positions.

Administrative Assistant to Finance Officer: Full-time civilian administrative assistant positions to the finance officer exist at two hospitals. The finance officers at both hospitals agree that this position is necessary for peacetime operations. When necessary, the civilian in charge of one of the sections, usually the accounting section, can perform collateral duty as administrative assistant. This position should therefore be eliminated from the finance division organization.

Storeroom Supervisor and Personnel: Three of the hospitals have a civilian in charge of the storeroom, one has a Hospital Corps officer, and one has a chief pharmacist's mate. The storerooms which are staffed entirely by military personnel are not run as efficiently as those which are supervised by a civilian storekeeper. The main reason is that most corpsmen who are assigned to the storeroom are neither trained as storekeepers or interested in becoming storekeepers; consequently, they make more mistakes in their work and often do not try to improve themselves. The stores are not checked or recorded accurately upon receipt and issue, and there is a considerable amount of issuing material to friends "under the counter" without requiring a requisition. As a result, the amount of many stores items actually in stock does not tally

with the amounts listed on the stores records. Frequent inventories, and corresponding inventory adjustments, are necessitated by such carelessness.

It is highly desirable to place a qualified civilian storekeeper in charge of the storeroom and hold him accountable for all material in the issue bins and bulk storerooms. In addition, he will be responsible for training all personnel, whether civilian or military, who are assigned to this section. Continuity, which will be afforded by the civilian in charge, is particularly important in this type of job. Hospital corpsmen, especially non-rated and the lower rated corpsmen, will be more valuable to the Medical Department in the wards, where their services are badly needed. Chief pharmacist's mates and pharmacist's mates, first class, however, can be assigned to the stores and equipment section, including the storerooms, for training purposes.

#### METHODS AND PROCEDURES

Medical Stores Records: The Kardex medical stores record system should be placed in operation at all hospitals. Representatives of the Bureau and the Remington Rand Corporation have developed an efficient modern stores record for use in naval hospitals. Four of the hospitals have either already installed, or are in the process of installing, the new system. However, San Diego still uses its own method. It is intended that the new record replace the Form "W" and certain other records now maintained to furnish information on stores ordered, received, and issued, usage rates, and the location of equipment.

Location of Stores Records: The new medical stores records system should be an integral part of the storeroom operation. Since the primary purpose of this system is to establish information on stores ordered, received, and issued, it is believed that operations will be facilitated and duplication of effort avoided if the record is physically located in the immediate storeroom area. Two hospitals now in the process of setting up the system have located the files in the main office rather than in the storeroom. As a result, the storeroom is maintaining duplicate stock cards in order to have necessary information available. This duplication wastes manpower and defeats the purpose of the new records system.

The Maintenance of Form W's: The maintenance of Form W's on stores should be discontinued when the medical stores records system is in full operation, since they will serve no useful purpose. One finance officer believed that the Form W's would still be required after the Kardex record was established. This is an erroneous conception and should be corrected.

Consolidation of Stores and Equipment Section: The responsibility for stores and equipment is not always assigned to the same organizational unit. In some instances stores and equipment personnel are entirely separate, both functionally and physically. While certain problems



pertaining to equipment do not apply to stores, and vice versa; nevertheless, work pertaining to both is sufficiently similar to warrant consolidation under one supervisor. Although specific personnel in this section would be primarily concerned with either stores or equipment, they would be interchangeable and therefore available for any duties required in connection with accomplishing the workload. As the volume of activity increases in any organization, action should be taken to reduce the number of organizational breakdowns and combine functions to facilitate economical performance. The tendency to maintain separate units where not absolutely necessary leads to over-organization, excess staffing, lack of coordination, and limited flexibility in personnel assignments.

Inventories: In two hospitals the finance division was attempting to conduct a complete inventory of all equipment assigned to the command. The inventory team had been working several months but the job was only partially complete. No real attempt was made to utilize operating personnel in inventorying specific divisions or services. For example, instead of requesting the medical librarian to inventory medical books, subject to instructions and guidance as required, one inventory team spent a month in the library. In order to save manpower and conduct large scale inventories as rapidly as possible, personnel working in a particular shop should accomplish the job with proper instructions from the finance division. This problem is of special significance since the Bureau of Supplies and Accounts requires periodic inventories of property at naval hospitals.

Marking Equipment for Location Control: It is necessary to assign a property number to each item of equipment valued in excess of fifty dollars. This number is usually imprinted on a metal tag which is then secured to the fixture. The process is both time-consuming and impractical, especially for small metal items. It is recommended that "decals" be used for identifying equipment. One of the large naval districts is already employing this method with satisfactory results.

Receiving Room: The receiving desk clerk prepares a receiving record or inspection form on orders delivered to the hospital and forwards it to the procurement section. This procedure is used even though the requisition is received in full. There appears to be no real necessity for the preparation of receiving records on complete shipments since the requisitions if appropriately marked, should be sufficient evidence of the receipt of the order.

Receiving rooms often maintain numerous logs and records containing complete information on shipments received. Practically all of these records are of questionable value as the receiving clerk checks the requisitions against the invoices for each item delivered. Consequently, it can be readily determined from the copy of the requisition that items have or

have not been received as ordered.

Stocks of Open Purchase Drugs: In some instances there are considerable stocks of drugs on hand which have been procured locally, either because of a temporary shortage or to comply with individual medical officers' requests. Such supplies remain unused and accumulate on the shelves when standard items are received from the supply depot or when the drugs are no longer required by individual doctors. A special effort should be made to utilize the remaining stocks of non-standard items in order to reduce top-heavy inventories, save space, and facilitate general stores maintenance.

Usage Rates: Many hospitals are replenishing stock without regard for usage rates. Such a procedure can easily result in getting either too few or too many of a particular item in stock. If the stock is depleted too soon, it is often necessary to resort to emergency open purchases. Drugs and other supplies are much more costly when ordered in small quantities from local concerns; consequently open purchases tend to increase procurement costs. The large amount of paper and record work involved in each purchase also increases hospital administrative costs. Conversely, overstocking is equally uneconomical, since excess time is consumed in handling, inventorying, and maintaining the unnecessary stores. One solution to the problem lies in the establishment of sound usage rates and order points, based primarily on past experience. The new Kardex stores system, if properly utilized, will furnish accurate data for usage rates and should improve the situation. Since the establishment of practical usage rates will result in more economical operations, each hospital should pay particular attention to this phase of the stores operation.

Expense Analysis Register: Recommendations concerning the Expense Analysis Register and a proposed modification of this form are discussed under "Work Measurement", Section IV of this report.

Pay and Allowances, Military Staff: Data for pay and allowances, military staff are maintained to determine military personnel costs for expense analysis purposes. Detailed procedures have been established to obtain exact information on daily assignments of military staff. One employee in the finance division devotes full time to obtaining, compiling, and computing such costs for each hospital. In addition, personnel in other divisions and services within the hospital spend considerable time in supplying required information. If all hospitals are considered, the expense involved in obtaining military cost data in the finance office alone is approximately \$50,000.

The final figures on military costs are not, and do not need to be absolutely accurate for expense analysis purposes. If military pay and allowances costs are computed on a monthly



rather than a daily basis, the expense involved in obtaining the data would be greatly reduced. At the same time the end result would be approximately the same because turnover is decreasing, and gains in staff would tend to compensate for losses. Consequently, overall costs, according to the breakdown on the Expense Analysis Register, would not be materially affected by conversion to a monthly basis.

Open Purchases: An open purchase is the procurement of drugs or other items by the hospital direct from a commercial concern. The purpose of the open purchase procedure is to permit emergency procurements and provide flexibility in obtaining necessary supplies for daily operations. Open purchases are often essential; but since they are more costly than standard medical supply items, they should be curtailed to a minimum consistent with effective hospital performance. In addition, each open purchase requires considerably more paper work.

In many instances supplies must be obtained locally, because the local naval supply activity does not fill orders promptly, or has been unable to deliver the items requisitioned. While the hospital cannot control the speed with which the supply depot fills the requisitions, it can establish sound usage rates and realistic order points, and order sufficient supplies far enough in advance of its needs to insure an adequate stock on hand at all times. When the delays at supply depots are unnecessarily long, the commanding officer of the hospital should bring the matter to the attention of the proper officials.

Form R's: Operating divisions and services use Form R's to request items from the storeroom. A new form should be designed to replace the Form R in submitting requests for housekeeping and other supplies used in large quantities. The new form should contain a detailed list of items so that operating activities can indicate their orders by merely checking the item, or items, desired and the quantity of each. The adoption of this simplified procedure would save time in both the submission and filling of requisitions by eliminating the preparation of many individual Form R's.

Civilian Payrolls: The procedures for preparing civilian pay rolls at most hospitals are unnecessarily involved and antiquated. At Great Lakes, three clerks are employed full-time for preparing pay rolls for 270 employees. At San Diego six clerks spend full-time on civilian pay roll and leave duties. The more obvious reasons why personnel are being wasted on the pay roll and leave functions are: (1) preparing rough draft pay rolls each pay period rather than using the pay roll of the previous pay-period, (2) unnecessary checking and rechecking, (3) making computations manually, (4) setting up pay rolls by typewriter instead of utilizing bookkeeping machines, and (5) collecting time cards daily, rather than weekly.

The Bureau of Supplies and Accounts Manual prescribes procedures for preparing pay rolls at non-industrial activities. If these procedures are followed with modifications to meet

local conditions, one full-time pay roll clerk should be capable of handling 200 pay roll accounts.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

Since it is extremely difficult to isolate an adequate work load indicator for the finance division which would cover the many varied phases of its operations, personnel requirements for finance are related directly to patient load.

The proposed standard staff requirements (Table 18) for the finance division do not include the civilian personnel function, or employees now temporarily employed on surplus property disposal.

Table 19 shows past staff performance for all five hospitals in terms of personnel engaged in the same functions on which the proposed standard staff requirements are based.

#### RECOMMENDATIONS

1. The organizational pattern of the finance division should be standardized so as to consist of a procurement section, an accounting section, a payroll section, and a stores and equipment section directly responsible to the finance officer.
2. Officers selected to supervise finance divisions should receive much more training particularly in accounting.
3. Officers who specialize in finance should not be rotated to other types of duty.
4. The civilian position of full-time administrative assistant to the finance officer should be abolished. When necessary, the civilian in charge of one of the sections, usually the accounting section can perform collateral duty as administrative assistant.
5. A qualified civilian storekeeper should be placed in charge of the storeroom and held accountable for all material in stock. Chief pharmacist's mates and pharmacist's mates, first class, can be assigned to the stores and equipment section, including the storeroom, for training purposes.
6. The new Kardex medical stores record system should be set up, and fully utilized by all hospitals.



7. Stores records are an integral part of the storeroom operation, and should be located in the immediate storeroom area rather than in the main finance office.
8. The maintenance of Form W's should be discontinued when the new stores record system is established.
9. Responsibility for both stores and equipment should be assigned to the same organizational unit -- the stores and equipment section.
10. Operating personnel should assist the finance division in conducting inventories of their particular division or service.
11. "Decals" should be used to mark small metal equipment.
12. Receiving records should not be prepared on requisitions received in full, since the requisition itself, if appropriately marked, should be sufficient evidence of the receipt of the order. Numerous logs and records maintained by receiving clerks are also unnecessary and should be discontinued.
13. Stocks of open purchase drugs (non-standard items) should be utilized to reduce top-heavy inventories, save space, and facilitate general stores maintenance.
14. Practical usage and realistic order points rates should be established, and utilized in the ordering of supplies.
15. Pay and allowances data for military staff should be maintained on a monthly rather than a daily basis.
16. Open purchases should be curtailed to a minimum consistent with effective hospital performance.
17. A simplified requisition form should be designed to replace the Form R for internal use in submitting requisitions for housekeeping and other supplies used in large quantities. The new form should contain a detailed list of items so that operating activities can indicate their order by merely checking the item, or items, desired and the quantity of each.

18. The civilian pay roll procedures should be simplified, and the number of pay roll clerks reduced. Maximum use is not being made of bookkeeping machines and other labor-saving devices.

19. The standard staff requirements, as proposed in Table 18, should be adopted.



TABLE 18

PROPOSED STANDARD STAFF REQUIREMENTS FOR FINANCE DIVISION  
(Excluding the Civilian Personnel Section)

<u>Patient Load</u>	<u>Staff per Patient</u>	<u>Staff Required</u>	
		<u>Total</u>	<u>% Military</u>
200	.060	12	40%
400	.040	16	35%
600	.033	20	35%
800	.027	22	35%
1000	.023	23	35%
1200	.020	24	35%
1400	.018	25	30%
1600	.016	26	30%
1800	.015	27	30%
2000	.014	28	30%

TABLE 19

PAST PERFORMANCE IN FINANCE DIVISIONS  
(Including Civilian Personnel)

	<u>PORTSMOUTH</u>		<u>PHILADELPHIA</u>		<u>GREAT LAKES</u>		<u>SAN DIEGO</u>		<u>NEWPORT</u>	
<u>Date</u>	<u>Staff</u>	<u>Staff per Patient</u>	<u>Staff</u>	<u>Staff per Patient</u>	<u>Staff</u>	<u>Staff per Patient</u>	<u>Staff</u>	<u>Staff per Patient</u>	<u>Staff</u>	<u>Staff per Patient</u>
<u>1946</u>										
Jan	42	.036	34	.011	64	.009	54	.013	30	.025
Feb	36	.030	41	.015	73	.012	50	.013	25	.022
Mar	34	.032	36	.014	73	.015	48	.014	25	.023
Apr	33	.033	38	.015	69	.016	54	.018	31	.035
May	32	.034	38	.017	71	.018	68	.028	27	.037
Jun	31	.035	36	.018	70	.022	71	.037	27	.043
Jul	24	.028	38	.020	55	.020	70	.040	25	.042
Aug	25	.040	43	.028	59	.028	57	.034	28	.050
Sep	22	.038	39	.027	51	.031	47	.030	28	.046
Oct	26	.049	37	.027	37	.029	47	.030	27	.045
Nov	22	.048	32	.025	32	.027	44	.031	26	.046
Dec			27	.022	34	.033	46	.034	24	.048
<u>1947</u>										
Jan			27	.022	40	.043	48	.034	23	.042
Feb			28	.023	37	.042	47	.034	24	.038
Mar							45	.033	25	.039
Apr									23	.035
<u>PATIENTS</u>										
400		.048								.043
600		.042								.035
800		.032				.042				.023
1000		.033				.038				.024
1200		.033		.022		.028				
1400				.026				.033		
1600				.028		.031		.031		
1800				.020				.040		
2000				.018				.037		
2200				.017		.028				
2400				.015				.028		
2600				.014						
2800				.015		.020				
3000				.011		.021		.018		





## DISBURSING OFFICE

### ORGANIZATION

A Supply Corps officer assigned by the Bureau of Supplies and Accounts is responsible for supervising disbursing office functions. It is general practice for this office to report directly to the executive officer. Although the disbursing officer is responsible to the Bureau of Supplies and Accounts on technical matters, he is administratively responsible to the local command and should operate on the same basis as the chiefs of the other administrative divisions at the hospital. Therefore, organizationally, the disbursing office should be under the administrative officer and report to him rather than the executive officer.

There is often no clear understanding of the relationship between disbursing officers and other hospital authorities. One reason that this situation exists is that the Bureau of Supplies and Accounts pays the salaries of disbursing office employees and the Bureau of Medicine and Surgery controls personnel ceilings. Some hospitals are not sure of the specific responsibilities of each Bureau in connection with ceiling and funds. As a result, disbursing offices are often treated as a separate entity, particularly when reductions in force occur. Whenever a reduction in force becomes necessary in a hospital, whether instigated by the Bureau of Medicine and Surgery or the Bureau of Supplies and Accounts, both disbursing and Medical Department personnel should be included in ceiling adjustments. Personnel from both groups who hold similar positions or perform corresponding functions should be considered in the same competitive levels for purposes of reduction in force.

In some hospitals the disbursing office keeps its own time and leave records and prepares its own pay roll. There is no reason why the disbursing office should act independently in this respect. The same office which prepares the pay roll for all other employees at the hospital should also prepare the one for disbursing.

A Bureau directive clarifying the jurisdictional relationship between the disbursing office and the remainder of the hospital would be beneficial to the hospital.

### METHODS AND PROCEDURES

Payment for Hospitalization by Supernumerary Patients: Some hospitals are lax in collecting hospitalization charges from supernumerary patients prior to their discharge from the hospital. As a result, considerable time is required to write or otherwise contact these people



and request payment of the money which they owe. In many instances the individuals cannot be located easily. Some do not send the money promptly when they are located, consequently the hospital has to send additional follow-up letters. This situation, which entails considerable waste of time and money and often causes confusion, can be avoided if the hospitals establish sound procedures to assure the collection of this money prior to discharging the patients.

The agent cashier should be responsible to the disbursing officer for collecting charges for hospitalization from dependents and other supernumeraries. He should be notified when these patients are admitted to and discharged from the hospital. When they are admitted at night or on a weekend, the officer of the day should notify the agent cashier either the following morning or Monday morning, as the case may be. The agent cashier should collect a deposit covering ten days' hospitalization in advance, wherever possible. In all cases, however, the patient should settle the bill in full or make satisfactory arrangements for payment prior to leaving the hospital. It is particularly important, therefore, that the agent cashier be notified sufficiently in advance of the discharge data so that he can make certain that all outstanding accounts are paid before the patients leave.

#### STAFF REQUIREMENTS

The proposed standard staff requirements for the disbursing office are shown in Table 20. The total personnel employed in the disbursing office at the five hospitals for the past twelve to eighteen months are listed in Table 21.

#### RECOMMENDATIONS

1. Since the disbursing office is administratively responsible to the local command, it should be located organizationally under the administrative group, and report to the administrative officer rather than directly to the executive officer.
2. The Bureau should issue a directive clarifying the jurisdictional relationship between the disbursing office and the remainder of the hospital.
3. Both disbursing office and Medical Department personnel who hold similar positions or perform corresponding functions should be considered in the same competitive levels for purposes of any reductions in force effected by the hospital.

4. The disbursing office should not keep its own time and leave records and prepare its own pay roll.
5. The agent cashier should be responsible to the disbursing officer for collecting charges for hospitalization from dependents and other supernumerary patients. A deposit covering ten days' hospitalization should be collected in advance, wherever possible.
6. Hospitals should establish local procedures to assure the collection of hospitalization charges from supernumeraries prior to their discharge.
7. The standard staff requirements, as proposed in Table 20, should be adopted.



TABLE 20

## PROPOSED STANDARD STAFF REQUIREMENTS FOR DISBURSING OFFICE

<u>Patient Load</u>	<u>Estimated Total Accounts (+ 200)</u>	<u>Accounts per Staff</u>	<u>Staff per Patient</u>	<u>Staff Required</u>
200	400	100	.020	4
400	700	150	.013	5
600	1000	175	.010	6
800	1300	200	.009	7
1000	1600	200	.008	8
1200	1900	225	.007	9
1400	2200	225	.007	10
1600	2500	225	.007	11
1800	2800	225	.007	12
2000	3000	225	.006	13

TABLE 21  
PAST PERFORMANCE IN DISBURSING OFFICES

Date	PORTSMOUTH		PHILADELPHIA		GREAT LAKES		SAN DIEGO		NEWPORT	
	Staff	Staff per Patient	Staff	Staff per Patient	Staff	Staff per Patient	Staff	Staff per Patient	Staff	Staff per Patient
<u>1946</u>										
Jan	20	.017	17	.006	64	.009	49	.012	10	.008
Feb	20	.017	16	.006	60	.010	52	.013	10	.009
Mar	20	.019	15	.006	52	.011	47	.013	10	.009
Apr	20	.026	14	.006	29	.007	32	.011	10	.011
May	20	.022	13	.006	24	.006	32	.013	9	.012
Jun	9	.010	12	.006	22	.007	26	.013	7	.011
Jul	9	.010	11	.006	26	.009	25	.014	7	.012
Aug	9	.015	11	.007	16	.008	24	.014	7	.012
Sep	8	.014	11	.008	12	.007	23	.015	7	.012
Oct	8	.015	11	.008	13	.010	22	.014	6	.010
Nov	8	.017	11	.008	12	.010	20	.014	6	.011
Dec			11	.009	12	.012	20	.015	6	.012
<u>1947</u>										
Jan					12	.013	18	.013	6	.011
Feb					12	.014	18	.013	5	.008
Mar							17	.013	5	.008
Apr									5	.008
<u>PATIENT LOAD</u>										
400		.017								
600		.015								.010
800		.010				.014				.011
1000		.020				.012				.010
1200				.009		.010				.008
1400				.008				.013		
1600				.007		.007		.014		
1800				.006				.014		
2000				.006		.008		.013		
2500				.006				.013		
3000				.006		.007		.011		





## MAINTENANCE DIVISION

Paragraph 1514 of the Manual of the Medical Department states that "the maintenance officer shall have charge of all maintenance and security of offices, shops and equipment, ...supervise the duties of the fire marshal...be responsible for the maintenance and operation of the power plant...laundry, garage, and similar installations."

The use of the word "security" in this definition of duties is ambiguous. The security function in maintenance overlaps the responsibilities of the master-at-arms, and has been subject to various interpretations. It is recommended that the word "security" be deleted wherever it occurs in paragraph 1514.

### ORGANIZATION

The maintenance division at the present time includes the following units:

- a. Office force and supervision
- b. Laundry
- c. Transportation
- d. Power Plant
- e. Shops (carpenter, electrical, paint, plumbing, etc.)
- f. Grounds (labor force, gardening, incinerator operation, trash collection, etc.)
- g. Civilian Janitors (where necessary)
- h. Elevator Operators (where necessary)
- i. Fire Department (or under master-at-arms)
- j. Civilian Guards (or under master-at-arms)
- k. Safety

\*NOTE: In the hospitals where the civilian guard force is under the master-at-arms, better liaison with the military security force is maintained.

In general, the fire department is under the maintenance officer because of the Manual requirement, but functionally, there is little reason for this setup. Among the duties of the fire department is the fire prevention inspection service, most of which involves personnel and materials of the maintenance division. It is generally considered poor practice to place an inspection service under the supervision of the department which it inspects. Elsewhere in the report, it is recommended that in medium and large hospitals, a Hospital Corps officer



be designated as security and disciplinary officer. This officer, rather than the maintenance officer, should be responsible for the guard force and the fire department.

The technical aspects of safety should remain as a collateral duty of the maintenance officer, but the clerical work on records and reports pertaining to the safety program should be handled by the personnel division. This arrangement will require close collaboration between the personnel office and the maintenance office in all matters pertaining to safety.

The maintenance officer should continue to be responsible for the functions (a) to (h) listed above.

Consistency in Supervision: There is no consistency in the manner or type of top supervision in the Maintenance Division. At Portsmouth there are a maintenance officer, an assistant maintenance officer, a civilian foreman, and two assistant foremen. At Philadelphia, the maintenance officer is a Civil Engineer Corps officer, having divided authority with a Hospital Corps officer who acts as first-lieutenant, and assisted by two chiefs and two civilian foremen. At Great Lakes, a chief pharmacist's mate is, in effect, the maintenance officer; and at San Diego, the maintenance officer is a line lieutenant, assisted by a chief machinist. Confusion results through the lack of clearly delegated responsibilities to these officers. One maintenance officer should be delegated full responsibility for all maintenance operations. It is doubtful if more than one maintenance officer is necessary, provided he is assisted by a competent civilian maintenance supervisor.

The excess civilian supervision is partially an aftermath from wartime functions which have now been curtailed (Exhibit 20). In some cases, organizations are deliberately twisted in order to obtain higher ratings for top civilian positions. At present there are many assistant foremen who are merely performing the work of head carpenters, head electricians, or the like. These inequities cause many morale problems and should be eliminated.

All commanding officers with whom the problem was discussed are fully aware of the problem and anxious for a solution, but are hesitant to act in the absence of directives. They unanimously agreed that the motivating force must come from the Bureau to assist them in maintaining satisfactory day-to-day relations with their personnel, particularly those supervisors who must be demoted.

It is estimated that approximately \$100,000 is involved in excess civilian supervision in maintenance divisions at all naval hospitals, plus an indeterminate amount because of the serious morale problem.



The problem of excess supervision should be solved by a competent Bureau representative in consultation with commanding officers to determine where exceptions should be made to the basic organizational pattern, as in cases of employees approaching retirement or other circumstances. This problem is more fully discussed in the section of the report on "Civilian Personnel".

Standardization of Division Organization: Because of the organizational confusion existing at some of the hospitals, it is necessary to standardize the internal organization of the maintenance division. The organization depends to a considerable extent on the size of the hospital, and patterns have been recommended for two sizes of hospitals. Exhibit 18 is the recommended supervisory organization for hospitals of 1200 patients; and Exhibit 19 that for hospitals of 600 patients. The latter should be applied to all hospitals ranging from 400 to 900 patients.

#### PERSONNEL

The Maintenance Officer and Foreman Mechanic: Technical engineering education and/or experience and continuity in the position are two of the essential requirements for top-level supervisory positions in the maintenance division.

Hospital Corps officers have, in general, failed to meet either of the above specifications. Consequently, there has been considerable criticism of their performance as maintenance officers. Moreover, in most instances, they have been supported by foremen mechanics who, have been promoted from trade jobs, and who do not have the requisite technical background for maintenance supervisors.

Billets have been, and probably more will be, established for Civil Engineer Corps officers as public works officers (or maintenance officers) at naval hospitals. This practice has the definite advantage of utilizing technically trained officers, but still presents such disadvantages as non-continuity in the job and often inadequate control at the hospital level. Although it might be preferable to appoint a competent civilian as maintenance engineer, the necessity for military liaison with Public Works makes the employment of a Civil Engineer Corps officer a more practical solution.

Continuity is nevertheless a prime requisite. It would be logical to consider the Civil Engineer Corps maintenance officer and his assistant, the civilian maintenance supervisor, as one position in the normal organizational pattern. The key position of maintenance supervisor should be filled with a civilian of appropriate technical and supervisory background.



From observations made at the hospitals and from opinions expressed by commanding and executive officers, it is apparent that the majority of foremen mechanics have not only failed to meet technical requirements for the position, but also do not have the necessary supervisory qualifications to support the military maintenance officer.

A new position should be established for a civilian maintenance supervisor to replace the present foreman mechanic. Minimum requirements for this new position should include two years' college education in mechanical or civil engineering, or equivalent experience, plus appropriate supervisory experience. Men for this position should come from industries, such as construction or contracting, building maintenance, etc. It is estimated that the position would pay about \$300 a year more than the present foreman mechanic position. In general, most present foremen mechanics would not qualify for this position, although the survey team observed at least one who would be suitable. Present foremen mechanics would be replaced as they retired, placed in other positions such as assistant foremen, or, where absolutely necessary, removed from the position. Exceptions, of course, would be made where justified.

Disposition of Buildings Not in Use: Each of the hospitals have buildings which are no longer being utilized. Two hospitals have over a half-million square feet of building space not in use.

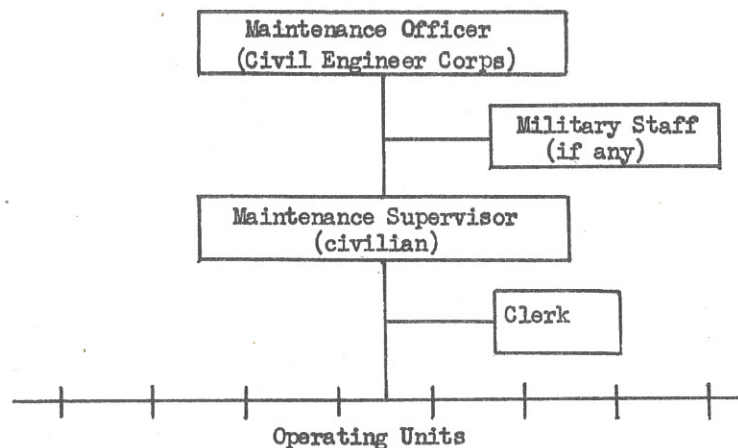
In some hospitals, as at San Diego, unused buildings can be permanently secured, and require practically no maintenance or unusual fire protection. However, at the Portsmouth and Great Lakes hospitals, there are many old World War I wood structures which require regular maintenance and fire protection. Further, these old buildings detract considerably from the appearance of the hospital.

The survey team was advised that these old structures are sub-standard for ward use, and would require considerable modification if placed in service. They are definitely a fire hazard, are expensive to heat, particularly in northern climates, and unquestionably require additional maintenance.

Where the military situation permits, those excess and obsolete buildings should be demolished. It is believed that salvage returns from the buildings would minimize the cost of removal.

## RECOMMENDATIONS

1. The maintenance division should include the following functions:
  - a. Office force
  - b. Laundry
  - c. Transportation
  - d. Power Plant
  - e. Shops
  - f. Grounds
  - g. Civilian janitors (where necessary)
  - h. Elevator operators (where necessary)
  - i. Safety (technical aspects only)
2. Responsibility for the operation of the guard force and fire department should be transferred to the security officer.
3. The technical aspects of the safety function should remain as a collateral duty of the maintenance officer; but the clerical aspects, including the keeping of records and the preparation of reports, should be reassigned to the personnel division. This arrangement will require close collaboration between the personnel office and the maintenance office in all matters pertaining to safety.
4. The organization of the maintenance division for a hospital of 1200 patients and one of 600 patients recommended in Exhibits 18 and 19 respectively, should be adopted.
5. The organizational pattern of the maintenance division generally should be limited as follows:





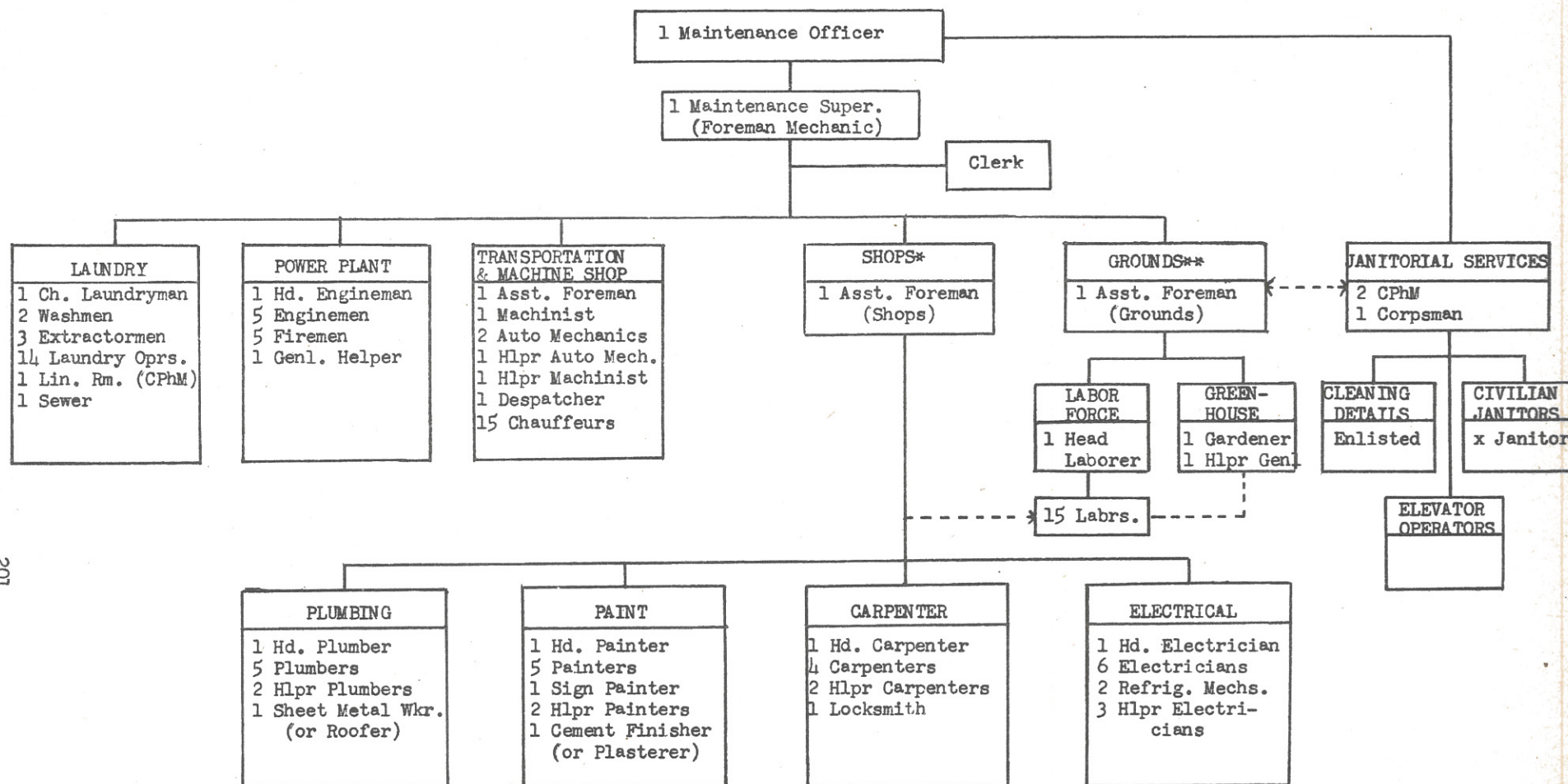
One maintenance officer, preferably a Civil Engineer Corps officer, should be delegated full responsibility for all maintenance operations. He should be assisted by a competent civilian maintenance supervisor.

6. The problem of excess supervision which exists at the present time should be solved by a competent Bureau representative in personal consultation with individual commanding officers to determine where exceptions should be made in the basic supervisory pattern, as in the case of employees approaching retirement.
7. A new position of a civilian maintenance supervisor should be established in lieu of the present foreman mechanic to improve the quality of maintenance supervision. Minimum requirements for this position should include two years' college education in mechanical or civil engineering, or equivalent experience, plus appropriate supervisory experience.
8. Obsolete and surplus buildings should be demolished where the military situation permits, particularly where they would require considerable modification if placed in service.

# MAINTENANCE DIVISION

Exhibit 18

## RECOMMENDED ORGANIZATION (at 1200 patients)



\*The Asst. Foreman (Shops) controls assignment of laborers for unusual maintenance normally under the jurisdiction of the shops.

\*\*Close liaison is necessary between the Asst. Foreman (Grounds) and CPhM for the most efficient use of enlisted work details.

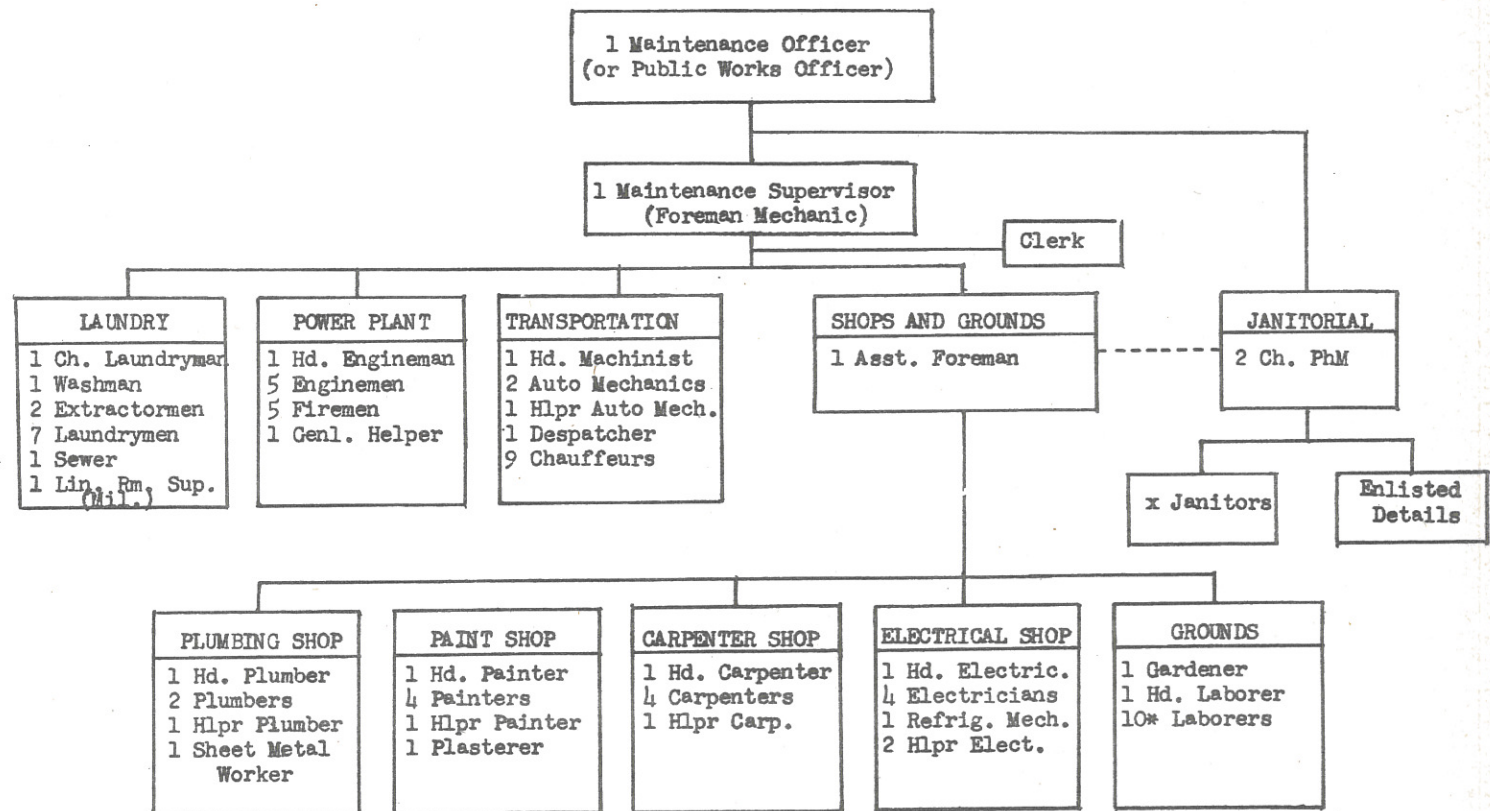




# MAINTENANCE DIVISION

Exhibit 19

## RECOMMENDED ORGANIZATION (at 600 Patients)



\*Number of laborers depends on use of patient details; 10 laborers at 600 patients assumes no patient use for lawn work.

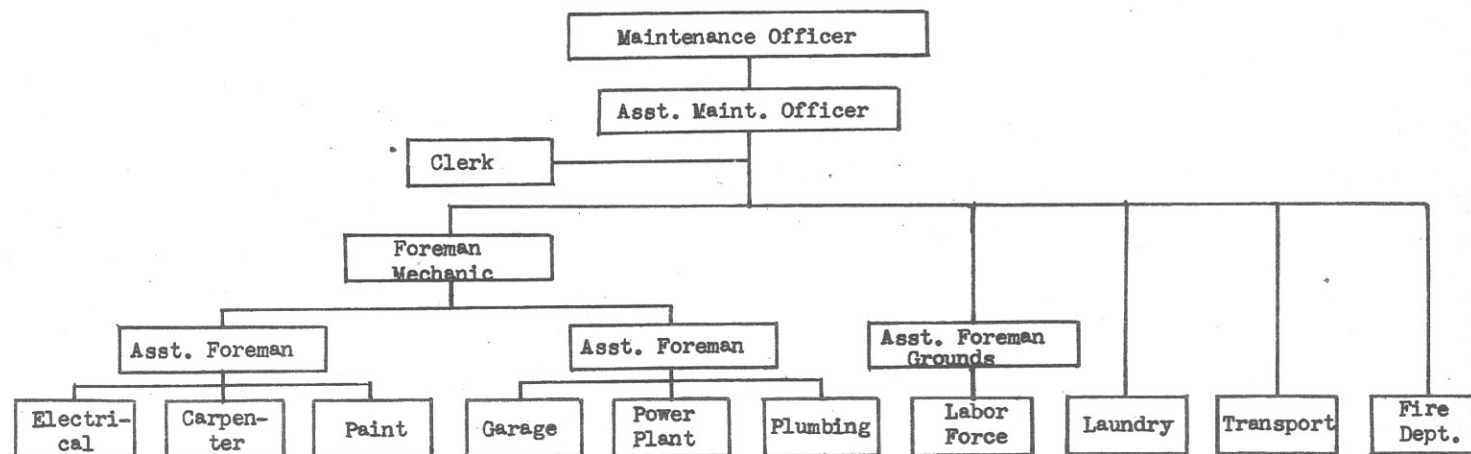




PORTSMOUTH NAVAL HOSPITAL

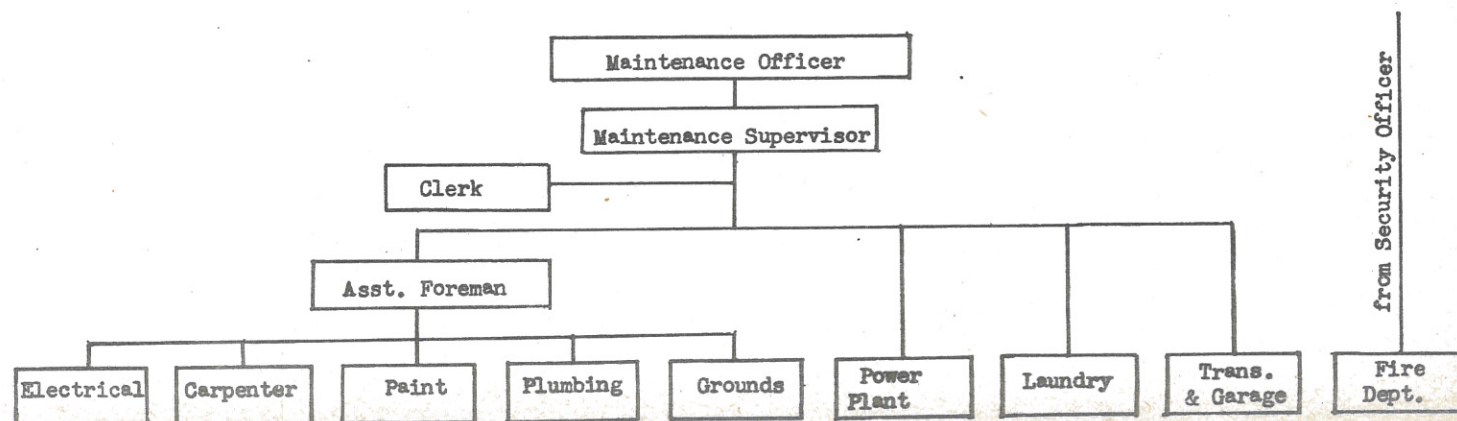
Exhibit 20

MAINTENANCE DIVISION -- PRESENT ORGANIZATION



MAINTENANCE DIVISION -- PROPOSED ORGANIZATION

Eliminates 2 Asst. Foremen, 1 Asst. Maintenance Officer, and 1 Unit Head (Garage)







## LAUNDRY AND LINEN ROOM

The internal operation of hospital laundries is essentially the same at all the hospitals. The equipment consists of washers, extractors, tumblers, and mangles, plus some ironers remaining from the discontinued Ship's Service Laundry. The linen room, in all but one hospital, adjoins the laundry and, in effect, is an integral part of the laundry operation.

The variables in the laundry process are external to the laundry itself, chiefly in the method of delivering laundry to and receiving laundry from the wards. This latter phase of the process depends primarily on the physical layout of the individual hospital.

Rough Cost Analysis: The following is an annual personnel cost estimate based on the most recent month for which data is available. This estimate can be considered typical of present operations.

<u>HOSPITAL</u>	<u>STAFF</u>	<u>AT PATIENT LOAD</u>	<u>ESTIMATED ANNUAL PAYROLL</u>
Portsmouth	21	530	\$45,000
Philadelphia	40	1,220	85,000
Great Lakes	18	880	40,000
San Diego	32	1,350	70,000
Newport	11	650	23,000

The staff includes laundry workers (generally civilian), linen room workers (military and civilian), sewers (civilian), and permanently assigned delivery service personnel (civilian and military).

The cost of laundry supplies is less than 10 percent of the labor charges. Utility charges are minor in comparison with labor, and are relatively inflexible. A variable cost is that of linen losses, on which great emphasis has been placed by all hospitals. Actually, however, linen losses have been averaging much less than \$1,000 per quarter, which is minor in comparison with the labor charges.

Therefore, for purposes of analysis, the emphasis should be placed on the two chief cost variables: (1) production per laundry worker, and (2) amount of laundry used per patient (refer to section on "Work Measurement").

### ORGANIZATION

According to paragraph 1514.4 of the Manual of the Medical Department, the maintenance officer "shall be responsible for the maintenance and operation of the laundry, and required



records and reports concerning the laundry".

In practice, the laundry operates independently, little control being necessary or exercised by the maintenance officer. Administratively, however, it is best to continue line responsibility to the maintenance officer in order to relieve the administrative assistant of additional duties.

The Laundry and Linen Room: The chief organizational problem in the laundry is the existence of organizationally independent but overlapping activities, the laundry and the linen room. The separation of these mutually dependent units is unnecessary from an operating standpoint.

Most commands doubt the necessity of using a nurse as the supervisor of the linen room. The linen room nurse is generally no more familiar with the use of linen than the average chief laundryman, or a competent chief pharmacist's mate. The major positive argument is that the linen room can often be used as a "shelf" job for nurses who for some reason require relief from full-time ward duty. (Only one case of this type was observed, however.) Controlling the usage rate on the wards is more important than controlling linen losses. If control of linen losses is to come from the central linen room, a more aggressive and interested individual is required than is likely to be obtained on a "shelf" job. If a young, capable nurse is used, then the argument loses its weight.

Observations have shown that little control can be exerted by the central linen room over usage rate, or over linen losses. The real control is a responsibility of the ward nurse or professional services supervisor. The central linen room can only maintain a statistical record, and report apparent over-usage or excessive losses to the appropriate ward and the executive officer.

In the related problem of the chief laundryman, it is absolutely essential that high quality supervision be maintained over the laundry workers to obtain production. Under present operating conditions, with reduced work load, the chief laundryman's supervisory skills are not fully utilized and hospitals cannot afford supervisors both in the laundry and the linen room. A chief laundryman with supervisory qualifications for a laundry would also be qualified for linen room duties. To this end, a competent and adequately paid chief laundryman must be employed.

It is general practice to use corpsmen for linen room and delivery duties, apparently for the purpose of giving the linen room nurse military control. If corpsmen are retained on these duties, they cannot receive adequate training in their rate. It is not considered



good practice to use corpsmen consistently for linen room duties.

There are, further, the problem of duplicate counting, a time-consuming operation; and the problem of split responsibility for linen losses in the laundry. Both problems are aggravated by split supervision.

To obtain smoother operating performance, eliminate excessive and sometimes conflicting supervision, and effect economy in personnel costs (about 15 percent), it is recommended that:

1. The central linen room should be eliminated as a separate entity and made part of the laundry as a storage, issue, and repair room.
2. The chief laundryman (or laundry supervisor) should be made responsible for maintaining records of overall linen inventory and the amounts issued to the various departments. A chief pharmacist's mate should be assigned to the linen room for liaison with the ward corpsmen.
3. Paragraph 16A 32.5 of the Manual of the Medical Department, which states "The senior Nurse Corps officer shall have charge of the linen room, etc.", should be changed to read as follows:

"The senior Nurse Corps officer shall be responsible for controlling linen usage and losses in wards and in those activities where a Nurse Corps officer is normally employed as the supervisor. She shall make certain that an accurate linen record is maintained in each ward or department."

At the present time, there is a tendency on the part of many ward nurses to shift responsibility for controlling linen usage and losses to the linen room nurse, who is not in a position to exert this control. One of the chief purposes of these recommendations is to place the responsibility for the control of linen usage in the individual wards and services, where it most properly belongs to be effective. The heads of activities where a nurse has no control, such as the commissary or clinic, will be responsible for their own linen usage. The chief laundryman, or chief pharmacist's mate in the linen room can judge by experience in hospital requirements when usage is excessive, with due allowance for periodic variations, and should so inform the department head. Control can be exercised only by the department head, who is responsible for his department's operations. Cases of long standing and



continued abuse should be referred to the executive officer or administrative officer, as appropriate.

It is interesting to note that the great majority of commanding officers, executive officers, and Hospital Corps officers believe that the use of a nurse in the linen room is unnecessary. Nurses are divided about equally on the question. If the linen room is integrated with the laundry as proposed, the question of whether a Nurse Corps officer in the light of the nurse shortage should be used as a linen room supervisor, rather than a chief pharmacist's mate or a civilian, becomes merely academic.

#### PERSONNEL

Distribution of Civilian Workers: The distribution of civilian workers in the laundry, by grades, was as follows:

	<u>PORTSMOUTH</u> (460)	<u>PHILADELPHIA</u> (1200)	<u>GREAT LAKES</u> (700)	<u>SAN DIEGO</u> (1350)	<u>NEWPORT</u> (650)	<u>HOUSTON</u> (380)
Patient Load						
Chief Laundryman	1	1	1	1	1	1
First Laundryman	2	4	* 3	7	4	1
Laundryman	4	14	* 1	9		
Laundry Operator	6	12	* 7	9	3	10
	<u>13</u>	<u>32</u>	<u>12</u>	<u>26</u>	<u>8</u>	<u>12</u>

\* Plus two corpsmen; plus two to five patients.

Inconsistencies in the interpretation of job titles are obvious. In this connection a major error exists in the basic circular letter SECP (now OIR) - 412:s11, dated 28 April 1945, in that it is impossible to distinguish between the duties of laundryman and laundry operator. Even where the definitions are relatively clear, they are misused. There is no consistency in the method of assigning first-laundrymen and laundrymen, or laundrymen and laundry operators. In effect, changes in job titles and hence grades have been based almost entirely on the availability of funds with little attention to the duties performed.

From observations, it is probable that a thorough job analysis would show the following distribution: (The laundryman position is interpreted to be on the skill level of extractor-man, dry tumblerman, or positions with exceptionally heavy physical demands.)

<u>Present Title</u>	<u>Proposed Title</u>	<u>15 Workers</u>	<u>30 Workers</u>
Chief Laundryman	Chief Laundryman	1	1
First Laundryman	Washman	1	2
Laundryman	Extractorman	2	3
Laundry Operator	Laundryman	11	24



The amount of immediately recognizable financial loss incurred annually by each hospital by the improper distribution of positions is as follows:

Portsmouth	\$ 900
Philadelphia	2100
Great Lakes	1100
San Diego	2600
Newport	2200
	<u>\$8900</u>

If the remainder of the naval hospitals operate similarly, a total of \$30,000 can be considered unnecessarily wasted in laundries because of improper grade distribution.

More important than pure economy is the necessity for correcting the inequity that exists when workers perform the same duties, but receive different rates of pay. The basic labor concept, "equal pay for equal work", is definitely being violated. It is most important to correct these inequities in order to maintain an incentive for production. The organization, in terms of grades, should be limited as follows:

<u>Patient Load</u>	Less than 200	200 to 600	600 to 1000	1000 to 1400	1400 and up
Chief Laundryman	1	1	1	1	1
Washman	1	1	1	2	2
Extractorman		1	2	2	3
Laundryman		3 to 9	9 to 15	15 to 19	19 and up

Pay Rates: The rates established for three of the four laundry jobs, namely laundry operator, laundryman, and first-laundryman, compare very favorably with similar jobs in civilian laundries in the area. Actually, the laundry operator job pays from 15 to 50 percent more than the same job outside in the areas studied.

The top job, chief laundryman, however, compares very poorly, not only with the same job in civilian laundries, but with jobs of similar skill levels within the hospital organization itself. In all five hospitals the chief laundryman receives from 18 to 26 cents an hour less than such non-supervisory personnel as the carpenter, plumber, and painter. In some hospitals the differential is as much as 34 cents. Compared with a similar job in civilian laundries, the hospital chief laundryman salary is from \$25 to \$75 per month less.

It should be noted, however, that not all present chief laundrymen are qualified for the position. Establishing a correct rate of pay for chief laundryman should not result in



automatically raising the pay of all incumbents. The man must be selected for the job, rather than the pay suited to the man. Where present chief laundrymen are not adequate supervisors, they should be replaced.

#### METHODS AND PROCEDURES

Production Planning: The equipment is the same and the basic technical process is the same at all hospitals. The main problem within the laundry is the physical routing of the laundry from the entrance to the exit. This is a problem which in private industry is part of the foreman's job, but the foreman can usually call on higher skilled professional industrial engineers for assistance on layout, timing, and production planning.

Transportation of Laundry: The main problem outside the laundry, but part of the laundry process, is the method of transporting laundry between the wards and the dry-building. It is doubtful if a standard procedure can be established since the physical layout of the individual hospital is the controlling factor. Although the problem is purely local in character, it acquires large dimensions when the time involved is considered. The average hospital spends approximately 100 man-hours daily on delivery and pick-up service, exclusive of counting and sorting time. Most of the 100 man-hours involve corpsmen assigned to wards and professional services. Reducing this time to a minimum becomes an important local management consideration, which requires skilled (and continual) staff engineering advice.

Local Procurement: Certain types of fabric articles made by the sewer can be procured locally. It is probable that hospitals now employing two and three sewers could get along with one sewer by applying a closer control on approval of these special articles.

#### REPORTS AND FORMS

The basic forms used in laundries are the Laundry List, NAVMED-HF-21, and inventory forms. Basic records consist of inventory logs and laundry production reports. However, no two hospitals follow the same method of maintaining or controlling inventories. The survey team noted considerable local duplication of forms and duplicating records in both the laundry and linen room.

The Laundry List, NAVMED-HF-21 should be revised and used for both laundry lists and periodic inventories. Local forms should be eliminated.

All hospitals should maintain daily records and report monthly production in the same



terminology as on the revised NAVMED-HF-21. This method of reporting should be standardized in terms of pieces of laundry. At present, where reporting is in pounds of laundry, the poundage is arrived at by a formula conversion from pieces of laundry, rather than by actually weighing.

The method of maintaining inventory records should be standardized.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

Variables in Determining Staff Requirements: The two chief variables in determining the total staff requirements for laundry operations at various patient loads are (1) the production per laundry worker, and (2) the amount of laundry used per patient.

The personnel overhead factor in a laundry is extremely low, i.e., a laundry can theoretically operate with as few as five employees (e.g., the number required to operate a mangle, plus a washman). From the basic minimum the number of workers required varies in a fairly direct ratio to the number of patients.

Output per Worker: Considerable statistical data was gathered in developing work load data. Table 23 shows the output at each hospital in terms of pieces of laundry per worker, per month, which is the total pieces of laundry handled divided by the total staff for that month.

In analyzing these statistics to arrive at a fair standard concerning the output per worker, full consideration has been given problems arising over the past year due to the decrease in patient load. For example, cuts in laundry workers generally lagged far behind corresponding drops in patient load. At Portsmouth, production performance for the last few months of 1946 was only half of that of the previous year. Great Lakes typifies the poor performance immediately preceding staff cuts (July and October, 1946). Even San Diego, with its generally excellent performance, shows improvements in production after personnel layoffs. Newport statistics show exceptionally high performance but include considerable use of corpsmen and patients, and, to be realistic, should be lowered by 15 percent.

In consideration of the facts available and observations made at hospitals where overstaffing was readily admitted, a standard performance expectancy should be 7000 pieces of laundry per worker per month. It should be noted that this standard is tentative and subject to constant analysis.

Laundry Use per Patient: Table 23 shows the number of pieces of laundry used per patient



per month over the past 12 to 18 months in each hospital. In arriving at an expectancy figure, the analyst has made no attempt to develop theoretical usage rates. Time has allowed only an estimate based on past performance at various patient loads. However, no satisfactory reason has been discovered as to why linen usage should vary greatly between general naval hospitals. Such factors as climate, types of service, and number of bed patients do not vary appreciably and, hence, apparently are not too significant. Further, the survey has not been able to find a satisfactory explanation as to why usage rate per patient rose so sharply with the drop in patient load.

Proposed Personnel Requirements: Table 22 shows the laundry worker requirements based on the developed usage rate and production standards.

Causes of Excess Costs: The application of these workload statistics typifies the excellent control, and isolation of weak spots which can be obtained from hospital to hospital production comparison.

For example, Portsmouth, Philadelphia, and Great Lakes show fairly normal usage rates. Portsmouth and Philadelphia, however, show poor production per worker; obviously a case of overstaffing. Great Lakes shows a production approaching the standard. San Diego's production is superior, but shows a usage rate above normal. Newport shows considerable understaffing, but a study disclosed that corpsmen and patients were being employed.

By applying the standards, excess costs as a result of the present lack of close control can be tabulated as follows:

<u>CAUSES OF ANNUAL EXCESS COSTS</u>			
	<u>POOR PRODUCTION PER WORKER</u>	<u>EXCESS USAGE RATE</u>	<u>TOTAL</u>
Portsmouth	\$18,000	0 plus	\$18,000
Philadelphia	32,000	0 plus	32,000
Great Lakes	0	0	0
San Diego	0	\$25,000	25,000
Newport	0	0	0
			<u>\$75,000</u>

In comparison to a total present laundry payroll for the five hospitals of \$263,000, effective control should result in about a 20 percent saving in laundry costs, or, for all hospitals, approximately \$200,000 annually.



## RECOMMENDATIONS

1. a. The central linen room should be eliminated as a separate entity, and made part of the laundry as a storage, issue, and repair room.

- 
- b. The chief laundryman (or laundry supervisor) should be made responsible for maintaining records of overall linen inventory and amounts issued to the various departments. A chief pharmacist's mate should be assigned to the linen room for liaison with the ward corpsmen.

2. Paragraph 16A 32.5 of the Manual of the Medical Department, which states "The senior Nurse Corps officer shall have charge of the linen room, etc.", should be changed to read as follows:

"The senior Nurse Corps officer shall be responsible for controlling linen usage and losses in wards and in those activities where a Nurse Corps officer is normally employed as a supervisor. She shall make certain that an accurate linen record is maintained in each ward or service."

3. A job analysis should be made of laundry occupations. It is suggested that the four basic jobs, as at present, be retained, but properly defined by position descriptions and adequately graded. Pending a thorough job analysis of laundry occupations the definitions in circular letter SECP-412:sll dated 28 April 1945 should be interpreted as follows:

Chief Laundryman: As given

First Laundryman: Use the definition for "Washman".

Laundryman: Dry Tumblerman, Extractorman, Marker and Sorter, or exceptionally heavy work such as associated with Puller (which is more often part of the Extractorman's job). Use the definition for "Extractorman".

Laundry Operator: Laundry Worker and Mangle Hand. Use the definition for "Laundryman".

Immediate instructions should be sent to the naval hospitals to follow these definitions, outlined in SECP instructions, for establishing their organizations.



4. The organization in terms of grades, should be limited as follows:

Patient Load	Less than 200	200 to 600	600 to 1000	1000 to 1400	1400 and up
Chief Laundryman	1	1	1	1	1
Washman	1	1	1	2	2
Extractor man		1	2	2	3
Laundryman	3	3 to 9	9 to 15	15 to 19	19 and up

5. The rate of pay for chief laundryman should be adjusted to conform to local area wage practices; and every effort should be made to insure that competent and fully qualified chief laundrymen are employed before these rates are applied.
6. The Laundry List, NAVMED-HF-21 should be revised and used for both laundry lists and periodic inventories. Local forms should be eliminated.
7. All hospitals should maintain daily records, and report monthly production in the same terminology as on the revised NAVMED-HF-21 form. This method of reporting should be standardized in terms of pieces of laundry. The method of maintaining inventory records should be standardized.
8. The performance standards shown on Table 22 should be adopted.
9. Hospitals should report the following factors quarterly in order to provide effective control.
- a. Patient load
  - b. Number of pieces laundered.
  - c. Number of laundry workers employed (include all personnel).

These factors should be used to determine the number of pieces laundered per patient, and the number of pieces laundered per laundry worker.

TABLE 22

**PROPOSED STANDARD STAFF REQUIREMENTS FOR LAUNDRY OPERATION  
(Performance Standard)**

<u>Patient Load</u>	<u>Expected Pieces of Laundry Per Patient Per Month</u>	<u>Expected Total Pieces of Laundry Per Month</u>	<u>Pieces of Laundry Per Worker Per Mo.</u>	<u>Laundry Workers Required*</u>
200	150	30,000	5,000	6
400	145	58,000	6,000	10
600	140	84,000	6,500	13
800	135	108,000	7,000	16
1000	130	130,000	7,000	19
1200	125	150,000	7,000	22
1400	120	168,000	7,000	24
1600	115	184,000	7,000	26
1800	110	198,000	7,000	28
2000	105	210,000	7,000	30

\* Laundry Workers - includes all civilian laundry workers, sewers, linen room staff (including nurse, if assigned), delivery truck drivers and attendants (if used), etc. Does not include ward corpsmen who count, delivery, and pick up laundry as an incidental task of their regularly assigned duties.



TABLE 23

PIECES OF LAUNDRY PER WORKER PER MONTH - PAST PERFORMANCE  
(Total Staff - including Laundry, Linen Room, Delivery Truck, Etc.)

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	3000	4800	3200	6900	4600
Feb	3600	4400	2800	5300	5200
Mar	3400	5100	3100	6100	5500
Apr	3500	5200	3500	6000	5300
May	4100	4700	3800	5300	4200
Jun	4500	4600	3300	4900	4700
Jul		5100	6700	7600	5500
Aug	4300	5600	5600	7000	5400
Sep	2930	5300	4200	6200	5900
Oct	3200	5400	4500	8100	5300
Nov	3000	4300	6600	8100	5200
Dec		4500	7100	8100	8000*
<u>1947</u>					
Jan			6600	8800	7400*
Feb			5800	8400	7800*
Mar				8500	8300*
Apr					9300*
Avg. From					
Jan 1946	3550	4910	4770	7020	6100

\* Less 15% for use of Enlisted details

#### NUMBER OF PIECES LAUNDERED PER PATIENT PER MONTH

<u>Patient Load</u>					
3000 plus	71	81	91	138	
2000-3000	95	94	105	184	
1500-2000	133	132	99	192	
1000-1500	135	140	127	195	102
500-1000	160		120		152

## TRANSPORTATION SECTION

The transportation section of the maintenance division usually includes the garage and the chauffeur force. In two hospitals, part of the duties include mechanical repairs on such equipment as power-driven lawn mowers, and deck polishers.

Personnel costs represent approximately 75 percent of the total operating expenses in the transportation section. Most of the following discussion, therefore, is concerned primarily with labor costs.

### ORGANIZATION

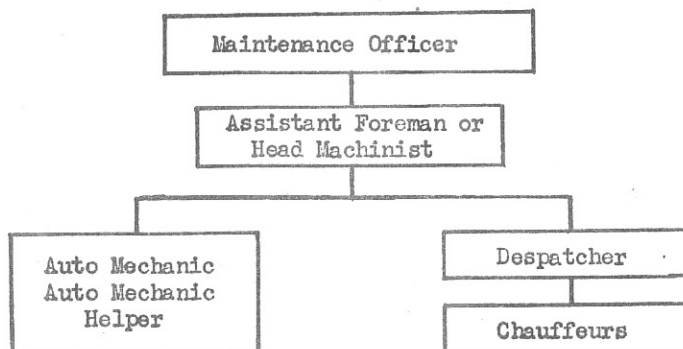
The transportation section reports to the maintenance officer in each hospital. Below is the variable organization found in the five hospitals:

Portsmouth	Philadelphia	Great Lakes	San Diego	Newport
Chauffeur Section	1 Chief (m)	1 Chief (m)	1 Asst. Foreman(c)	2 Auto mechanics(c)
2 Despatchers(m)	2 Despatchers(m)	3 Despatchers(m)	1 Head chauffeur(c)	
5 Chauffeurs(m)	2 Chauffeurs(m)	4 Chauffeurs(m)	19 Chauffeurs(c)	2 Chauffeurs(c)
6 Chauffeurs(c)	17 Chauffeurs(c)	1 Head chauffeur(c)	1 Machinist(c)	(4 Corpsmen on extra duty at night.)
Garage	1 Head machinist	8 Chauffeurs(c)	3 Auto mechanics(c)	
1 Head machinist	3 Auto mechanics	1 Machinist	1 Painter(c)	
4 Auto mechanics	1 Helper machinist	3 Auto mechanics		
19	27	21	26	4

m - military personnel  
c - civilian personnel

At Portsmouth, the garage is independent from the chauffeur unit, while at the other hospitals these units are combined. There is excessive top supervision from head chauffeurs, dual supervision from a head machinist and from a chief of the section and too many dispatchers.

The transportation section should be established with the assistant foreman (over 900 patients) or the head machinist responsible directly to the maintenance officer as follows:





The despatcher (one) would be assigned for day duty only. The despatching at night would be handled by the chauffeur on duty through the officer of the day. The despatcher's collateral duties would include all record-keeping and reporting.

#### PERSONNEL

Misuse of Job Titles: It is noted that two categories of job titles are generally misused:

1. The title of "Machinist" is often used in lieu of "Automotive Mechanic" because it pays about six cents an hour more. No more than one machinist is necessary, and this should be the head machinist.
2. The title of "Automotive Mechanic" is too often used for "Helper, Automotive Mechanic". In four hospitals there is only one helper compared to 17 mechanics and machinists, yet the garage in a naval hospital is far more a service station than a repair shop. The definition for helper calls for all lubrication, routine battery service, all tire repairs, and "lesser skilled duties involved in auto repair, and in making minor adjustments".

Rate Inequity: The automotive mechanic receives from six to eight cents an hour less than trade workers, such as carpenter, plumber, and painter. It is doubtful if this inequity is justified. This is the one trade where real shortages existed over the past year, and where Navy rates are below the comparable rates in the local area.

Some hospitals do not use chauffeurs for any duties except driving, other hospitals are hesitant to assign them to other duties, particularly loading vehicles. This situation results from a misunderstanding of Civil Service regulations and the fear of violating customary trade practices.

It is a common trade practice to use drivers for loading and unloading vehicles. Even the Guide Line Job Description (SECP-412:s11, dated 28 April 1945) states "assists in loading and unloading trucks". Further, it is a basic management prerogative to set-up jobs to perform the duties required. The Civil Service Commission regulates the hiring procedure and, for certain positions, wage rates, but is not normally concerned with how the job is organized. The chauffeur who performs loading duties would have no wage grievance because the rate for a chauffeur is almost always higher than for a laborer. It is not as

if a laborer were assigned chauffeuring duties without additional compensation.

#### METHODS, PROCEDURES, AND REPORTS

The basic procedures are simple, but they are not the same in any two hospitals. Different types of records and logs are maintained, and there is no consistency as to the assignment and performance of the duties involved. In some hospitals, the despatcher maintains the records; in others, the head chauffeur.

The record procedure should be simplified and standardized by using the two basic forms, the Vehicle Trip Report, NAVEXOS-371, and the Daily Log Sheet, NAVEXOS-280. Duplicating logs should be eliminated. The day despatcher should keep these records in addition to submitting reports on mileage, gasoline and oil consumption, requisitioning, and inspections. The head machinist could then act as a working supervisor with very few clerical responsibilities.

The hospitals, in general, operate more vehicles than are necessary. While this does not particularly complicate the chauffeur problem, it does add to the work of the mechanics because of the routine inspection and maintenance requirements. The number of hospital vehicles in operation, particularly such types as trucks and station wagons, should be reduced to the minimum necessary to provide adequate service.

There is inevitably much dead-time in a chauffeur's work-day. The peak workload occurs early in the morning. Chauffeurs have little to do for the balance of the day. The problem of equalizing this work is a local problem which needs considerable attention.

Another problem is the chauffeur coverage necessary for night operations. In three of the hospitals, night chauffeurs are exclusively corpsmen, while the remaining two employ civilians, with corpsmen available for emergency duty.

The use of corpsmen for full-time garage duty has the advantage of flexibility in working hours, but it is considered better safety practice to use civilian chauffeurs for driving outside the compound. Then too, garage work is of no value in training corpsmen for duties in their rate.

Corpsmen should be used in the garage, or as chauffeurs, only as a standby night watch or in emergencies.



## WORK MEASUREMENT AND STAFF REQUIREMENTS

The personnel overhead factor is considerable when computing the minimum staff required to operate a garage. It is estimated that eight workers (one automotive mechanic, one helper, and six chauffeurs, including coverage on night watches) are required for the smaller hospitals. For larger hospitals the staff requirements increase with the patient load, although not in direct proportion.

Variable Factors: The two chief variables in determining worker requirement are (1) the mileage (or gasoline consumption) per patient, and (2) the mileage (or gasoline consumption) per garage worker.

The mileage per patient is affected considerably by local conditions, but not to the extent that some general expectancy cannot be determined. It is believed that comparisons among hospitals will show more consistency in the future.

Table 25 shows the "Miles per Patient per Month" over the past 18 months at four hospitals. With due allowance for demobilization conditions and sometimes loose control, the miles per patient, in general, drop as the patient load increases, in the order of magnitude as indicated by the table.

Table 25 shows the "Miles per Staff per Month". There is considerable inconsistency, but it is sufficiently valid to arrive at a standard of 700 miles per worker per month.

The statistics themselves show the overstaffing above overhead requirements as the patient load dropped. Portsmouth and Philadelphia typify low performance as a result of overstaffing. Great Lakes and San Diego show improvement in performance after staff cuts were applied. Newport shows below minimum staff requirements.

Table 24 shows "Proposed Staff Requirements", based on an empirical expectancy of miles per patient per month, and a standard performance of 700 miles per worker per month. Because of the influence of local conditions and the fact that the statistics themselves are incomplete, the requirements should be applied plus or minus 20 percent.

To afford better control, hospitals should report monthly the total vehicle mileage and the number of transportation workers employed. From these, the mileage per patient and mileage per transportation worker can be computed to provide a basis for comparison against the standard.

APPARENT ANNUAL EXCESS PERSONNEL COSTS

	Due to Excess Staff	Due to Excess Mileage	Total
Portsmouth	\$12,000	0	\$12,000
Philadelphia	16,000	- 2,000	14,000
Great Lakes	10,000	0	10,000
San Diego	0	10,000	10,000
		Total	\$46,000 ±20%

It is estimated that for all naval hospitals, approximately \$200,000 ± 20 percent would be saved by more effective staff and mileage controls.

RECOMMENDATIONS

1. The organization should be established with the assistant foreman (over 900 patients) or the head machinist responsible directly to the maintenance officer.
2. The hospitals should follow the definitions for machinist (automotive), automotive mechanic and helper, automotive mechanic listed in the Navy Department Guide Line Job Description.
3. The position of automotive mechanic should be analyzed and rated in comparison to other hospital occupations and existing area rates.
4. Corpsmen should be used in the garage or as chauffeurs only as standby night watch or in emergencies, but not full-time.
5. The transportation procedure should be simplified and standardized around two basic forms - The Vehicle Trip Report, NAVEXOS-371, and the Daily Log Sheet NAVEXOS-280; duplicating logs should be eliminated.
6. Such administrative duties as preparing the Vehicle Trip Report, the Daily Log Sheet, and other required mileage and gasoline and oil consumption reports, requisitioning materials, and making inspections should be assigned to the day dispatcher.
7. The number of automotive vehicles in operation, particularly trucks and station wagons, should be reduced to the minimum necessary to provide adequate service.



8. The performance standards shown on Table 24 should be adopted.
9. To give better control, hospitals should report monthly the total vehicle mileage and transportation workers employed. From these, the mileage per patient and mileage per transportation worker can be computed.

TABLE 24

## PROPOSED STANDARD STAFF REQUIREMENTS FOR TRANSPORTATION

<u>Patient Load</u>	<u>Miles per Patient per Month</u>	<u>Total Miles per Month</u>	<u>Miles per Transportation Worker per Month</u>	<u>Transportation Workers Required (<math>\pm 20\%</math>)</u>
200	15	3,000	400	8
400	14	5,600	600	9
600	13	7,800	800	10
800	12	9,600	800	12
1,000	11	11,000	800	14
1,200	10	12,000	800	15
1,400	9	12,600	800	16
1,600	8½	13,600	800	17
1,800	8	14,400	800	18
2,000	7½	15,000	800	19

\* Includes all military and civilian personnel assigned full-time to the transportation section, such as supervisors, automobile mechanics, chauffeurs, and despatchers.



TABLE 25

MILES PER PATIENT PER MONTH, TRANSPORTATION SECTIONS  
(Past Performance)

<u>Patient Load</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
3000 plus		6.3	13.3	16.0	
2000 to 3000		8.7	8.2	19.5	
1500 to 2000		9.5	7.4	22.0	
1000 to 1500	16.5	9.0	11.1	15.4	7.2
500 to 1000	15.3		11.5		10.9

-----

MILES PER STAFF\* PER MONTH

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
January	800	460		880	460
February	640	470		850	530
March	910	600		840	500
April	650	550	690	880	400
May	640	440	600	680	650
June	710	530	510	620	450
July	540	340	520	910	620
August	630	480	360	800	650
September	410	370	390	620	730
October	540	460	480	880	700
November		380	570	660	640
December		440	690	510	930
<u>1947</u>					
January			650	760	1840
February			530	1030	1020
March				840	1690
April					1660
May					1130
Average	650	460	540	780	860

\* Includes all military and civilian personnel assigned full time to the transportation section, such as supervisors, automobile mechanics, chauffeurs, and dispatchers.

## POWER PLANT

Each power plant generates steam locally for heating and other utility purposes. Two of the hospitals maintain generators for emergency electric power supply, but these generators are rarely used.

### ORGANIZATION, PERSONNEL, WORK MEASUREMENT

All power plants are completely staffed with civilian personnel. In each case, the supervisor of the power plant reports through the foreman mechanic to the maintenance officer. In general, the supervisors of the power plant are actually supervisory enginemen and not technically trained as mechanical engineers. Technical assistance and inspections are provided by local shipyards or stations.

The following is a tabulation of the organization of the power plants:

<u>Portsmouth</u> (oil)	<u>Philadelphia</u> (oil)	<u>Great Lakes</u> (coal)	<u>San Diego</u> (oil)	<u>Newport</u> (oil)
1 Asst Foreman	6 Enginemen	1 Asst Foreman	1 Asst Foreman	1 Engineman
6 Enginemen	6 Firemen	4 Enginemen	1 Hd Engineman	9 Firemen
6 Firemen		12 Firemen	4 Enginemen	
1 Laborer		3 Laborers	8 Firemen	
$\frac{1}{2}$ Pipefitter hlpr			1 Helper, Gen.	
<u>14<math>\frac{1}{2}</math></u>	<u>12</u>	<u>20</u>	<u>15</u>	<u>10</u>

It is general practice to use two men per eight-hour shift (one engineman and one fireman). Twenty-one shifts of two men each are required per week, or four and one-fifth, 2-man-teams for a 40-hour work-week. A total of 10 men, the minimum for operation, would allow 6.4 hours weekly per man for both annual and sick leave. A total of 11 men should be sufficient to handle routine maintenance and most emergencies. A complement of 12 would certainly cover most any contingency, including overlapping shifts.

Some hospitals are not balancing each work shift with one engineman and one fireman. In three of the five hospitals there is excess top supervision, and they are not using the time of the shift engineman and fireman properly for routine maintenance and cleaning. Most hospitals have no promotion-from-within plan for their personnel, which is particularly important in power plant operation.

The staff of the power plant should be organized into a working unit with the following complement:

- 1 Head Engineman
- 5 Enginemen
- 5 Firemen
- 1 General Helper (if necessary)



The head engineman should generally be on the day shift in charge of maintenance and cleaning, but available for engineman duty. The general helper should also be on the day shift, but could replace a fireman if necessary.

The system used at Philadelphia, Portsmouth, Newport, and San Diego can readily be adjusted to this pattern. Great Lakes has a coal-fired plant, and claims three men are required per shift for winter operations. The pattern in this case, for the winter months only, should be as follows:

- 1 Head Engineman
- 5 Enginemen
- 8 Firemen
- 1 General Helper

If the above recommended pattern is adopted, it is estimated that savings in annual personnel costs would be as follows:

Portsmouth	\$ 6,000
Philadelphia	-
Great Lakes	13,000
San Diego	8,000
Newport	(minus) 3,000
	<u>\$24,000</u>

For all naval hospitals, the savings would be approximately \$120,000.

Records: There is no consistency whatsoever in maintaining power plant operating logs. Some hospitals maintain extensive records of equipment operation, while other keep a record only of fuel consumption and steam flow. Most of the record keeping is theoretically under the direction of the nearest navy shipyard or other large navy installation.

Record keeping has little effect on personnel requirements because there is considerable dead time in power plant operation. However, instructions should be issued as to the minimum records required.

Consolidation of Power Plants: It is noted that power plant personnel costs are relatively inflexible in relation to patient load. This overhead factor becomes heavier as the patient load drops, but must be considered one of the fixed charges in operating a hospital.

If at all possible, power plants should be consolidated with those in adjacent naval activities. For example, it is probably possible at Great Lakes to use steam from the power plants at the training station. The steam line is already tied in with the hospital plant there.

Heating Secured Buildings: A large amount of steam is used for heating secured buildings, primarily because of sprinkler systems. Many of these buildings are old wooden structures dating from World War I. Because of lack of sufficient steam meters, it is difficult to estimate the amount of steam used, but it must be considerable. The heating problem introduces an additional factor which should be considered in determining whether or not old buildings should be demolished

or retained. (Refer to "Disposition of Buildings Not in Use" in the maintenance division section of the report).

#### RECOMMENDATIONS

1. The normal power plant should consist of the following personnel:

- 1 Head Engineman
- 5 Enginemen
- 5 Firemen
- 1 General Helper (if necessary)

2. Instructions should be issued from the Bureau as to the minimum power plant records required.

3. Steam generating facilities, particularly in small hospitals, should be consolidated with those available at adjacent naval establishments.

4. The cost of heating should be given full consideration as a factor in deciding whether or not obsolete and secured buildings should be demolished.



## SHOPS AND GROUNDS SECTION

The shops and grounds section is responsible for the true maintenance function. Other sections of the maintenance division (viz. laundry, power plant, transportation, etc.) involve utilities rather than maintenance. In the discussion below, the use of the word "maintenance" refers to the work performed by the shops and grounds section.

### ORGANIZATION

The section includes, functionally, the following activities:

1. Carpenter Shop
2. Paint Shop
3. Electrical Shop
4. Plumbing and Pipe Shop
5. Grounds Force (laborers, gardeners, incinerator and trash workers, etc.)

The grounds force operates independently from the shops generally, but there is a lack of coordination in assigning laborers, due primarily to improper lines of supervision. Personnel of the labor force are assigned temporarily to shops as needed.

In two hospitals, the pipe shop is either independent of the plumbing shop or is assigned to the power plant. This arrangement is inefficient, involving duplication with the plumbing shop. In two other hospitals, separate machine shops exist, thus duplicating work performed by the garage machinist.

The proposed organization of the shops and grounds section is outlined in Exhibits 18 and 19, and combines pipefitting and plumbing. It places machine shop work in the garage and coordinates the shops and grounds under a single supervisor.

Miscellaneous functions, which by themselves might only involve one employee full or part-time, would be assigned to the most appropriate shop. For example, sheet-metal and metal roofing would be assigned to the plumbing shop, locksmith work to the carpenter shop, and glass work to the paint shop, etc.

### PERSONNEL

Lack of Job Specifications: One of the problems created by reductions-in-force was caused by "bumping", where in many cases the replacements are not qualified to perform the duties of the workers displaced. "Bumping" is at best a compromise to seniority and pleasing to no one. The problem was made more difficult by lack of understanding of its modus operandi, and also because, in many cases, hospitals failed to specify the job requirements.

The title "Electrician" in naval hospitals covers occupations such as maintenance



electrician and refrigeration mechanic, and differs considerably from a construction electrician (as in navy shipyards). The category of "Carpenter" may include maintenance carpenter, furniture repairman, and locksmith, all dissimilar from a construction carpenter. Plumbers are generally qualified for low pressure pipefitting, but pipefitters are not usually plumbers. Job definitions are rarely referred to and even then the definitions are inadequate. The hospitals are and will continue to be placed in a difficult position during reduction-in-force as a result of the lack of, or inaccurate, job descriptions.

The same problem exists in hiring from Civil Service registers. The hospitals have a choice of applicants only to the extent of their failure to meet the job requirements. Lack of adequate current job specifications makes a choice difficult and subject to considerable controversy.

A job analysis study should be made as a basis for establishing minimum hiring requirements and to provide clear statements of duties.

Utilization of Grades: The shops and grounds section, in common with other sections in hospitals, shows in many instances improper utilization of pay grades, wherein workers perform duties of lesser skills than the title indicates.

Examples of the more flagrant violations are numerous. To illustrate, an employee with the title "Head Cement Finisher", at \$1.54 an hour, is actually a head gardener; an electrician, at \$1.44 an hour, is performing the duties of a CAF-2 clerk; many general helpers are performing the duties of laborers; laborers are performing maids' duties; and foremen are more often performing duties such as head carpenter, and head electrician.

Even more significant is the lack of use of the "helper" classifications. At some hospitals there are six to nine carpenters with at most one helper, and seven to ten painters with no helpers (Table 26A). The excessively high ratio of trade workers to helpers has occurred largely because of reduction-in-force, but there is much evidence that maintenance divisions in general do not realize the significance of the disproportionate ratio nor are they clearly informed as to what the differences actually are between the helper and the journeyman grades. Failure to use existing job definitions is a contributing factor.

Table 26B shows the excess cost in a typical shops and grounds section because of misuse of grades and grade definitions. As in most cases of bad grade usage, the real cost is not so much in the budgetary requirements as in the unsettled conditions which always result when employees receive different rates and classifications while performing the same work. It is the old concept of "equal pay for equal work". Inequities exist to a varying extent in all the maintenance



divisions studied. In one or two instances, the situation is reversed; - that is, laborers are being used to perform helper duties and even journeyman work. In these cases the resulting morale problems more than counter-balance any money savings.

An apparent solution is the proper training of supervisors. The most vital tools, however, are adequate job descriptions which will clearly define the scope of each job.

Definition of Trades: One of the most difficult problems facing the maintenance division presently is the lack of clear understanding as to what constitutes a trade and how jobs should be defined. For example, what is the difference between the duties of a plumber and a pipefitter? Should a chauffeur be required to load vehicles? Should the duties of a locksmith be incorporated in the duties of a carpenter? Is there any significant difference between a carpenter and a furniture repairman so far as job titles are concerned?

Many of the trade workers in the maintenance division come from AFL craft unions where the concepts of trade lines are clearly developed. These men naturally carry over the union concepts as to what constitutes their jobs. Hospital trades, however, cannot be compared to construction or other craft trades, but are much more similar to those in industrial organizations operating on a permanent basis. There is very little justification in an industrial organization for craft concepts other than those which are justified technically. In non-government industry, union bargaining, in most cases, concerns the amount of money that should be paid for the job rather than how the job should be organized.

One of the more basic management prerogatives is to establish and organize jobs in any manner that management sees fit. At the naval hospitals management has hesitated to exert its full prerogative in this respect, both because of lack of understanding of the difference between craft unionism and industrial unionism, and secondly, because of improper understanding of the functions of the Civil Service Commission. The Civil Service Commission does not generally concern itself with how a job should be organized, but only, as for IVb workers, how much the job should pay or what should be the hiring procedure.

Hospitals have been tremendously handicapped in this regard by a lack of appropriate job descriptions which clearly define the duties of the position. Before the above problem can be satisfactorily solved, the duties of all these positions must be clearly defined.

#### PROCEDURES

Work Repair Requests, NAVMED-63: The basic clerical procedures in the maintenance division



concern the Work Repair Request, NAVMED-63. These forms are initiated by the person requesting a repair, and forwarded, in most cases, to the executive officer for approval. The executive officer, in turn, routes the form to the maintenance officer who forwards it to the cognizant shop. At two hospitals, the maintenance officer approved all routine requests for repairs, and referred to the executive officer only those orders which he felt were unnecessary or which required the use of a considerable amount of materials and money.

The necessity for the executive officer to approve all repair requests tends to create a bottleneck and excessive work for either the executive officer or his assistant for administration. It should be necessary for the executive officer to approve only unusual requests for maintenance work. Improvement in the quality of foreman mechanics will enable more confidence to be placed in their judgment.

Control of Material: No hospital controls the use of maintenance material by individual shops. Further, the present method of estimating budget requirements based on overall expenditures is not satisfactory.

The expenditure of materials on a particular job should be noted on the reverse side of "Form 63", in order to control the expenditure of materials and to facilitate preparation of annual budgets.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

Establishing Personnel Requirements: Maintenance is one of the most difficult types of work in which to establish an equitable standard for personnel performance. The problem has been of particular concern to industry for many years and no sound solution has yet been effected. At best it has only been possible to establish overall worker requirements for the entire division rather than to establish standards for performance in individual jobs, such as in the paint shop, carpenter shop, etc. The number of workers required for maintenance operations (shops and grounds) depends chiefly on the physical layout with variations due to type and age of construction and changes in patient load. Basically, however, the number required depends on the square footage of the hospital and grounds.

Previous performance of shops and grounds workers at naval hospitals has been so inconsistent over the past two or three years that requirements can only be determined through considerable investigation by personal contacts as well as by statistical studies. Because of the wide fluctuation in shops and grounds staff over the past two years, the survey team is able only to determine at approximately what point personnel staffs are above or below minimum



requirements.

The relationship of the volume of Work Repair Requests, NAVMED-63, both to the square footage in use at the particular time, and to the workers employed is fairly consistent at individual hospitals (Table 27). The direct relationship of workers employed to the square footage is also consistent (Table 28). From the data gathered it has been possible to gauge approximately the complement in terms of square footage of buildings, acreage, and patient load. The following empirical formula has been developed to establish maintenance worker requirements for naval hospitals:

$$\begin{array}{l} \text{Workers Required} \\ \text{(Shops and Grounds)} \end{array} = 10 + \frac{\text{Square Footage}}{25,000} + \frac{\text{Acreage}}{10} + \frac{\text{Patient Load}}{100}$$

Using repair requests as overall workload indicators was seriously considered, but finally discarded because it is felt that the variation in the manner in which work repair requests are prepared might nullify the control of worker requirements. However, the consistent relationship of work repair requests and square footage serves to validate the formula as established (Table 27).

Comparative Performance and Excess Costs: Tables 28 and 29 show the inconsistency in the number of workers used for maintenance operations in some hospitals. In comparison with Portsmouth and Great Lakes, Philadelphia and particularly San Diego show poor performance not only in the relationship of the total number of workers per square foot (Table 29) but also in the number of work repair requests handled per worker (Table 28). Sufficient experience has not been gained to prove conclusively that worker requirements for maintenance operations depend solely on square footage. However, the independent check on worker performance by the number of repair requests handled by the individual worker serves as an excellent verification for conclusions regarding numbers of maintenance workers required.

From the above analysis, San Diego has 35 more workers in the shops and grounds section than would normally be required. The overall annual excess cost is approximately \$90,000 a year. Philadelphia's excess cost is estimated at about \$25,000 a year. On the other hand, Newport requires 12 more workers. Actually, the study at Newport disclosed that the shortage in maintenance personnel not only seriously affected day-to-day operations, but also Public Works or private contractors were performing work which was being performed by the maintenance division at other hospitals. At San Diego, a surplus of approximately 20 workers rather than 35 was noted, since the amount and quality of maintenance required is greater than at other hospitals. This example indicates that sound judgment must be used in applying the



formula to make allowance for unusual circumstances.

The recommended formula should be used to establish worker requirements for the shops and grounds forces at naval hospitals. Experience may require revisions in the formula but variations should not exceed 10 percent, at least for hospitals with more than 200 patients. Table 31 demonstrates the proposed shops and grounds staff for the hospitals studied as calculated by the proposed formula.

Table 30 is a summary of the square footage per patient at the hospitals. Using this table as the basis for predicting average square footage per patient, the survey team calculated the shops and grounds personnel requirements for an "ideal" hospital (Table 32).

#### RECOMMENDATIONS

1. The organization of the shops and grounds section shown in Exhibits 31 and 32 should be adopted.
2. A job analysis study and the preparation of adequate job descriptions should be undertaken immediately to provide clear statements of the maintenance positions for use in hiring, reduction-in-force, proper grade assignments, and to prevent misunderstandings as to what duties are required.
3. Misassignment of individuals with regard to pay grades should be corrected.
4. The maintenance officer should approve all routine requests for repairs. Only those orders which require the use of a considerable amount of materials and money or which appear unnecessary should be forwarded to the executive officer for review and decision.
5. The expenditure of materials on a particular job should be noted on the reverse side of NAVMED-63, Work Repair Request. This information should be used by the maintenance officer in determining the needs and controlling the use of materials by the individual shops.
6. The following formula should be used to determine the number of workers required in the shops and grounds section:

$$\begin{array}{l} \text{Workers Required} \\ \text{(Shops \& Grounds)} \end{array} = 10 + \frac{\text{Sq. Ft. Bldgs. in Use}}{25,000} + \frac{\text{Acres}}{10} + \frac{\text{Patients}}{100}$$



TABLE 26A

MAINTENANCE - SHOPS AND GROUNDS PERSONNEL  
PRESENT COMPLEMENT BY GRADES

	<u>Portsmouth</u>	<u>Phila.</u>	<u>Gr. Lakes</u>	<u>San Diego</u>	<u>Newport</u>	<u>Houston</u>
<u>OFFICE</u>						
Maintenance Officer	1	1	1	1	1	1
Asst. Maint. Officer	1	1	1	1	0	0
Clerk	1	1	1	1	1	1
Mil. Supervisors	0	2	3	2	3	5
Foremen & Asst. Foremen	<u>3</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>1</u>	<u>1</u>
	6	7	7	7	6	8
<u>ELECTRICAL</u>						
Asst. Foreman	0	0	0	1		
Head Electrician	0	0	1	1		1
Electricians & Refrig. Mech.	5	8	6	12	2	6
Hlpr. Electrician	<u>1</u>	<u>6</u>	<u>1</u>	<u>3</u>		<u>2</u>
	6	14	8	17	2	9
<u>CARPENTER</u>						
Asst. Foreman	0	0	1	1		
Head Carpenter	1	1	0	0		
Carpenter	6	5	9	7	3	3
Helper or Laborer	<u>1</u>	<u>6</u>	<u>0</u>	<u>1</u>		
	8	12	10	9	3	3
<u>MACHINE SHOP</u>						
Head Machinist	0	0	0	2		
Machinist	0	1	0	2	1	1
Helper	<u>0</u>	<u>1</u>		<u>2</u>		
	0	2	0	6	1	1
<u>PAINT</u>						
Head Painter	1	0	1	1		
Painter	4	6	7	10	2	2
Plasterer	1	0	0	0		
Helper or Laborer	<u>3</u>	<u>2</u>	<u>0</u>	<u>1</u>		<u>1</u>
	9	8	8	12	2	3
<u>PLUMBER</u>						
Asst. Foreman	0	0	0	1		
Head Plumber	1	1	1	0	1	
Plumbers	5	3	3	7		3
Pipefitter	0	1	2	4	2	
Helper and Laborer	1	5	2	1		
Sheet Metal and Roofer	<u>1</u>	<u>0</u>	<u>2</u>	<u>3</u>		
	8	10	10	15	3	3
<u>GROUNDS</u>						
Head Gardener	0	0	1	1		
Head Cement Finisher	1	0	0	0		
Gardener	0	1	0	3		
Cement Finisher	1	0	1	2		
General helper	1	0	6	10	1	1
Head Laborer	2	0	0	2		
Laborers	<u>15</u>	<u>12</u>	<u>5</u>	<u>13</u>	<u>5</u>	<u>* 10</u>
	20	13	13	31	6	11
GRAND TOTAL	57	66	56	97	23	38
Janitors (Laborer, helper)	4	19	0	14	0	12

\* Plus 27 laborers working on landscaping

TABLE 26B

## UTILIZATION OF GRADES

Shops and Grounds Section, Portsmouth

<u>Groundskeeping</u>			
<u>Title</u>	<u>Rate</u>	<u>Actual Number</u>	<u>Should Be</u>
Head Cement Finisher	1.54	1	0
Head Groundskeeper	1.38 (Est.)	0	1
Head Laborer	.98	2	1
Laborer	.82	19	19
Maid	.71	0	1
Cement Finisher	1.38	1	1
General Helper	.91	1	1
Average Rate		89.0	87.3
Saving			\$900 Annually

<u>Shops</u>			
Assistant Foreman	1.69	1	0
Head Carpenter	1.54	1	1
Carpenter	1.38	6	4
Helper, General	.91	1	3
Head Painter	1.54	1	1
Painter	1.38	4	3
Plasterer	1.54	1	1
Helper, General	.91	1	2
Laborer	.82	2	2
Head Electrician	1.54	0	1
Electrician	1.38	5	4
Helper Electrician	.91	1	2
Head Plumber	1.54	1	1
Plumber	1.38	5	4
Helper Pipefitter	.91	1	2
Sheet Metal Worker	1.38	1	1
		<u>32</u>	<u>32</u>
Average Rate		1.316	123.8
Saving			\$5200 Annually

Total Savings - Shops and Grounds

\$6100



TABLE 27

NUMBER OF WORK REPAIR REQUESTS IN MAINTENANCE DIVISIONS  
(Per Million Square Feet)

<u>Date</u>	<u>Portsmouth</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>				
January	1320	1360	2050	1420
February	1200	1160	1880	1370
March	1400	1210	1900	1480
April	1620	1180	1860	2150
May	1720	990	1750	2250
June	1300	980	1550	1870
July	1710	830	1290	1800
August	1490	1080	1340	1450
September	1460	1200	1370	1140
October	1530	1410	1880	1700
November	1470	1360	1530	1150
December		830	1420	1360
<u>1947</u>				
January		1280	1790	1620
February		1210	1580	1360
March			1450	1490
April				1280
Average From 1 July 1946	1530	1150	1520	1440

TABLE 28

## WORK REPAIR REQUESTS COMPLETED PER MAINTENANCE WORKER IN MAINTENANCE DIVISIONS

<u>Date</u>	<u>Portsmouth</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>				
January	16.	13.	8.5	14.
February	14.	12.	7.9	13.
March	15.	13.	7.6	16.
April	17.	13.	7.6	21.
May	17.	10.	7.4	22.
June	14.	12.	7.1	19.
July	19.	8.	6.8	20.
August	17.	19.	7.5	16.
September	17.	15.	7.7	12.
October	18.	17.	13.0	19.
November	18.	17.	10.8	17.
December		10.	9.8	26.
<u>1947</u>				
January		16.	13.6	26.
February		15.	11.3	23.
March			12.0	25.
April				21.
Average	16.	14.	9.2	19.



TABLE 29

## SHOPS AND GROUNDS PERSONNEL PER MILLION SQUARE FEET IN MAINTENANCE DIVISIONS

Date	PORTSMOUTH		PHILADELPHIA		GREAT LAKES		SAN DIEGO		NEWPORT	
	Wkrs. Per Million		Wkrs. Per Million		Wkrs. Per Million		Wkrs. Per Million		Wkrs. Per Million	
	Wkrs.	Sq.Ft.	Wkrs.	Sq.Ft.	Wkrs.	Sq.Ft.	Wkrs.	Sq.Ft.	Wkrs.	Sq.Ft.
<u>1946</u>										
Jan	87	84	112	130	117	102	207	244	46	102
Feb	91	88	112	132	113	98	203	239	47	106
Mar	92	92	112	133	111	96	213	251	39	91
Apr	94	97	110	133	102	93	209	246	43	102
May	93	101	111	135	107	97	203	239	41	100
Jun	84	95	110	136	85	82	183	218	40	100
Jul	73	89	110	138	102	102	157	189	36	90
Aug	65	86	108	137	52	58	147	179	36	90
Sep	62	86	110	141	66	82	146	180	37	92
Oct	61	85	79	103	62	83	115	144	36	90
Nov	55	81	69	91	58	83	112	142	27	68
Dec			68	91	52	80	113	145	21	52
<u>1947</u>										
Jan					51	79	101	131	25	62
Feb					53	81	96	126	24	60
Mar							91	121	24	60
Apr									24	60

TABLE 30

SQUARE FOOTAGE PER PATIENT IN MAINTENANCE DIVISIONS  
(Estimated at Designated Patient Loads)

<u>Patient Load</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
400	1500				
600	1200				700
800	900		700		500
1000	900		650		400
1200	850	600	600		380
1400		550	550	550	
1600		500	500	500	
1800		450	450	450	
2000		400	420	400	
2200		350	400		
2400		330	390	350	
2600		310	380		
2800		300			
3000		280	400	270	



TABLE 31

PROPOSED STANDARD STAFF REQUIREMENTS FOR SHOPS AND GROUNDS AT INDIVIDUAL HOSPITALS  
(Maintenance Division)

<u>Patient Load:</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
<u>Portsmouth</u>								
Sq.ft. in thousands	550	600	650	700	750	800	850	
Staff	44	48	52	56	60	64	68	
<u>Philadelphia</u>								
Sq.ft. in thousands		525	550	650	675	700	750	800
Staff		38	41	47	50	53	57	61
<u>Great Lakes</u>								
Sq.ft. in thousands		500	550	600	650	700		
Staff		40	44	48	52	56		
<u>San Diego</u>								
Sq.ft. in thousands		600	625	650	675	700	750	800
Staff		47	50	53	56	59	63	67
<u>Newport</u>								
Sq.ft. in thousands	360	380	400	420	450			
Staff	29	32	35	38	41			

TABLE 32

## PROPOSED STANDARD STAFF REQUIREMENTS - SHOPS AND GROUNDS SECTION

<u>Patient Load</u>	<u>Sq.Ft.Per Patient</u>	<u>Sq. Ft. of Buildings in Use</u>	<u>Acreage</u>	<u>Shops &amp; Grounds Workers Required</u>
200	1000	200,000	10	21
400	750	300,000	20	28
600	675	400,000	30	35
800	625	500,000	40	42
1000	600	600,000	50	49
1200	550	650,000	60	54
1400	500	700,000	70	59
1600	450	740,000	80	64
1800	425	770,000	90	68
2000	400	800,000	100	72

Shops and Grounds workers required were calculated on the basis of the empirical formula:

$$\text{Workers Required} = 10 + \frac{\text{Sq.Ft.bldgs. in use}}{25,000} + \frac{\text{Acreage}}{10} + \frac{\text{Patient Load}}{100}$$

Variations from the norm for square footage and acreage at individual hospitals must be expected and accounted for in establishing a more accurate standard. (See Table 31) Where full information is lacking, a more approximate formula can be used as: 80 workers per million square feet.



## JANITORIAL SERVICE

Civilian Janitors: About half of the hospitals use civilian janitors in the main buildings. They are used chiefly in buildings where traffic is heavy, where the cleaning routine is such as to make the use of daily changing patient details impractical, or where sufficient patient details could not be relied upon. Opinion varies as to their usefulness or economy in lieu of patient details.

The decision as to whether or not civilian janitors are to be employed should remain primarily with the individual command, tempered by existing local conditions.

Janitor Rates: Civilian janitors are titled and receive the pay for laborer. Generally, however, the job of laborer involves more arduous duties, and the practice in industry has been to set up a differential between janitors and laborers. The feeling that an inequity exists is apparent among the labor force at naval hospitals. A new rating should be established for janitors at naval hospitals.

Responsibility for Janitorial Service: Where civilian janitors are used, there is often a jurisdictional overlap between the responsibility of the maintenance division and the MAA for cleanliness. More often than not, patient details are not used properly in this type of work.

The maintenance division should be made fully responsible for the cleanliness of buildings and grounds, except those areas normally considered wards or services. The maintenance division, rather than the MAA, should also be responsible for the supervision of patient or other enlisted details on cleaning duties. All enlisted details should work under appropriate military supervision. Patient details are to be furnished directly by the detail desk (refer to section on Security and MAA Division).

## RECOMMENDATIONS

1. The individual command should determine whether to employ civilian janitors or use patient details for cleaning purposes.
2. A new rating should be established for janitors at naval hospitals.
3. The maintenance division should be made fully responsible for the cleanliness of buildings and grounds, except those areas normally considered wards or services.



## COMMISSARY DIVISION

### ORGANIZATION

The commissary division in all cases is supervised by a commissary officer who is directly responsible to the administrative officer.

The internal organization of the commissary division is basically the same at all the hospitals. Existing variations are due chiefly to physical layout. The following units generally constitute the division:

- Office and supervisory staff
- Storeroom
- Main Galley, including main serving line and night cooks
- Officers' Mess
- Special Diet Kitchen
- Meat Shop
- Bake Shop
- Cart Details
- Nurses' Mess

Special Diet Kitchen: The supervisors of the special diet kitchen are nurses. Considerable administrative difficulty was noted because the commissary officer had little control over the special diet kitchen, particularly in regard to the procedures for ordering and delivering special diets and, the coordination of this work with the overall commissary function.

The special diet kitchen should be administratively responsible to the commissary officer, so that he can effect the necessary coordination within his division.

Nurses' Mess: Portsmouth and San Diego do not have separate nurses' messes, the former because of economy, and the latter because the physical location makes a separate nurses' mess unnecessary. There are many arguments for and against a separate nurses' mess. Nevertheless, careful investigation at Portsmouth and Philadelphia disclosed only minor objections to a consolidated officers' mess, mostly among the older nurses. Most of the nurses realize that in small hospitals such a consolidation is necessary for economy of operation. It appears that where economy necessitates a consolidation of messes, no great objection would be raised.

Separate nurses' messes should not be operated for less than 40 nurses, or where the staff required would be more than one commissary worker for five nurses.

There is considerable inconsistency in the method of charging civilian workers in nurses' quarters to Expense Analysis Register accounts, particularly between "E-110 Commissary" and "E-303 Staff Quarters". Some of the hospitals charge all or part of the maids to the commissary, while others do not. The method outlined in the accounting procedure for prorating costs is not followed properly.

While it is true that some maids work in the nurses' mess during meal times, they spend a major portion of their time performing general housekeeping duties. The charge to commissary



is in most cases unrealistic. The commissary division should be charged only for cooks, mess attendants, etc., and titles changed if necessary, but the commissary division should never be charged for maid service.

The method of charging maid service in the nurses' quarters should be clarified (in some cases they are charged to maintenance). If, for the sake of flexibility, maids perform some dining room duties as an incidental portion of their main duty, this should be charged as part of their maid duties for staff quarters.

Supervision by Civilian Stewards: The amount and type of top supervision varies considerably. The number of commissary officers varies from one to three at each hospital. Great Lakes and San Diego use civilian stewards while Portsmouth has a steward in title, but who is actually performing the duties of chief cook.

The importance of utilizing a civilian steward for continuity is apparent in the smoothness and ease in operation of the commissary at Great Lakes and San Diego. Portsmouth is difficult to judge because of a particularly capable commissary officer and a stable civilian force. At Philadelphia, the job is too much for one officer, and at Newport lack of continuity shows its effect in high turnover.

Of particular note at the hospital studied, six civilians are titled "Steward", but four of these are improperly classified and actually perform the duties of chief cook or first cook.

One civilian steward should be employed at each hospital to provide the necessary continuity, to relieve the commissary officer of much of the overload, and to act in his absence. Hospital complements should be limited to one commissary officer and one steward. Only the large hospitals would require a chief cook in addition to a steward.

#### PERSONNEL

Rate of Pay: The rate of pay of the mess attendant, the basic job of the commissary division, compares very favorably with outside rates with the possible exception of Newport. The pay for the journeyman level worker (cook, baker, meat cutter, etc.) seems low in some cases. Stewards, chief cooks, and first cooks are particularly low paid.

A thorough job analysis should be made of commissary occupations as the first step in a wage survey. The first cook should be considered as a head cook and his pay set at \$0.10 per hour more than the maximum grade for cook. Appropriate differentials should be established for chief cook, and especially for the steward.

Excess Personnel in Higher Grades: The commissary division, in general, is the worst violator of the principle of equal pay for equal work. Partly as a result of the war, and partly because of failure to use existing job definitions, many workers are performing lower rated



duties than those called for by their titles. Table 33 shows the inconsistency between hospitals. No more than one steward and one chief cook should be employed at a hospital; and only San Diego and Philadelphia can justify both a steward and chief cook. A first cook is by definition a shift supervisor for a main galley, yet Portsmouth has eleven instead of three, Great Lakes six instead of four, San Diego eight instead of six, and Houston four instead of two. In most cases, too many cooks and assistant cooks are performing the duties of mess attendant.

About \$20,000 in excess rates is being paid annually at these five hospitals. The increased turnover, and poor production due to poor morale must increase this cost several times.

It is essential that these inequities be corrected. The first step is clear job definitions. The next step is training commissary officers in the use of these definitions. The third step is gradually carrying out corrective measures with the least impact, such as when and if rates are raised, during reductions in force, by replacements due to retirement and turnover, and, where absolutely necessary, by demotions.

Two-Shift vs. Three-Shift Method: At every hospital the turnover rate among civilian workers is highest in the commissary division. While causes of turnover are fairly well known, it is difficult to judge quantitatively the relative significance of each case. Mess attendant is an entry occupation and is beset by inequity in pay rates, low pay, and in some cases, poor and often arbitrary supervision. However, it is believed that irregularity in working hours is one of the chief causes of turnover. Staggered shifts are required because the commissary must be staffed seven days a week and approximately 12 hours a day, while civilians work only 40 hours a week.

Philadelphia, Great Lakes, and Newport use the so-called two-shift system. In general, the civilians worked "butted" shifts (for example, the first shift is 0600 to 1200 and the second shift, 1200 to 1800). They work three 6-hour days and two 11-hour days for a total of 40 hours at Great Lakes. At Philadelphia, however, they work five 6-hour days and one 10-hour day for a six day 40-hour week. Great Lakes works a five-day week but on the so-called long days uses a split-shift; i.e., the workers work only 40 hours per week, but in effect are required to be in the vicinity of the hospital for more than that time even though the time over 40 hours is their own.

Portsmouth and San Diego use the three-shift method, which is basically an eight-hour day, five-day week. The shifts overlap (for example, from 0600 to 1400 and from 1100 to 1900), but the peak workload is at the noon meal. One day a week, usually inspection day, an extra shift is used (15 shifts for 14 shift coverage). Most significant, Portsmouth



and San Diego show, by far, the lowest turnover of the hospitals studied, although the true situation at Portsmouth is obscured by the high relative pay rate for mess attendant.

A two-shift system is claimed to be more efficient in number of personnel required. The consensus of opinion in the field is that about 20 percent more workers would be necessary to convert from the two-shift to the three-shift system. There are many disadvantages, however, to retaining the two-shift system. The employees don't like it because of irregular working hours, fewer whole days or consecutive days off, and the length of some days. It is inefficient in that the time lost in starting and finishing a day is proportionately greater on a short day (six hours) and the fatigue element becomes too great on the long day. Absenteeism is unduly high on the long days, which affects patient service. Most commissary officers agree to the disadvantages, but are hesitant to convert without additional employees.

Whether a three-shift system is more or less costly depends primarily on the flexibility in the method of working the labor force. The supervision must be of high quality so that a full day's work is performed by each commissary worker. At present, commissary workers in too many instances are not being utilized to the maximum extent. At Philadelphia, for example, workers are assigned to carts, and perform that duty exclusively. As a result, there is considerable waste time. On the other hand workers at Portsmouth are moved from carts to mess lines to galleys at different times during the day, depending on where the heavy workload exists.

With a stabilized work force, and the resultant improvements in productiveness, and turnover and the cost of administration, it is extremely doubtful that the two-shift method is any more economical than the three-shift system in medium and large hospitals.

An eight-hour, five-day week should be established at hospitals employing more than 50 civilian commissary workers. To operate economically on this basis requires careful planning, and closer supervision than at present, both of which are desirable factors under any system.

Female Mess Attendants: Several hospitals claim that female workers are not suited for much of the heavy work, such as handling stores, heavy cleaning and washing pots, and that the employment of women limits the flexibility of the working force, particularly after reductions-in-force. The hospitals which did not complain about female workers use corpsmen exclusively in the commissary storeroom.

The chief cause of this problem is failure to specify the physical demands in the position description. If the description states such items as "must lift up to 75 pounds in moving stores" or "performs heavy work in cleaning pots and pans, and scrubbing decks", the Civil Service Commission will (or should) certify only those who can meet these requirements, or,



conversely, will allow exceptions in reduction-in-force where flexibility is necessary.

It is anticipated that the proper use of adequate job descriptions will solve the problem. In most of the larger hospitals, many of the mess attendant jobs can be adequately performed by female workers. Those attendants already on the job should be removed only where absolutely essential. Most of the female workers can ultimately be replaced as they resign or retire, or as reductions-in-force are made.

Use of Hospital Corpsmen in the Commissary: Each hospital uses a considerable number of corpsmen in the commissary, varying from eight at Portsmouth to nineteen at San Diego. The great majority of these corpsmen are hospital apprentices who work in the storerooms. About two or three in each case are chief pharmacist's mates or pharmacist's mates, first class, assigned permanently to supervisory jobs.

One reason for using corpsmen in the storeroom is to prevent pilferage. It is extremely doubtful, however, that pilferage is any greater in those storerooms which use only civilian workers. Another reason is the shortage of sufficient male workers, in some areas, to handle stores. A third reason advanced is that it is the only way to train future Hospital Corps officers, although it was readily admitted that this statement applied only to chief pharmacist's mates, first class.

Since commissary work offers little opportunity for nursing training, the use of corpsmen in the commissary division should be kept to a minimum. It should be restricted to chief pharmacist's mates and pharmacist's mates, first class, in supervisory jobs, and corpsmen specifically assigned to police mess lines at certain hours. Corpsmen should not be used as storeroom hands, diet kitchen helpers, etc.

#### METHODS AND PROCEDURES

Commissary Office Procedures: All hospitals keep complete records of expenditures for provisions, inventories, cost per ration, etc. However, the number of ledgers and the method used in maintaining the ledgers vary widely. A mass of duplicating and often seemingly unnecessary records are kept as the result of utilizing the personal ideas of commissary officers, inspectors, and civilian clerks, plus procedural carry-overs from previous local administrations.

The two basic daily reports, Ration Record, NAVMED-HF-36, and Receipt and Expenditure, NMSH Form 37, are of questionable value. The former is only used locally once a month, and the latter is completely duplicated by ledgers. The daily computation of ration cost is incomplete because the officers' mess and many other special messing arrangements are taken into account only once a month.



The commissary officers are of the opinion that the entire commissary procedure should be overhauled and standardized. They point out that when they are transferred from one hospital to another is similar to going on an entirely new job. Hospital Corps officers agree that the Commissary Department of the Hospital Corps School at Bethesda, Maryland, in conjunction with the Bureau, should undertake the task of standardization.

Forms: The commissary division uses a greater variety of local forms than any other division. Portsmouth uses over 30 forms and San Diego uses over 40. In some cases, basic forms such as the Diet Sheet, NAVMED-HF-18, are seldom used or entirely ignored in favor of local forms; yet these various local forms accomplish the same purpose at the different hospitals. The wide variety of forms in use for ordering special diets are particularly unnecessary.

There is no consistency as to which phases of the accounting and buying procedures are to be handled by the commissary, and which by finance, particularly in regard to the preparation of vouchers.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS:

From 15 percent to 20 percent of the total staff of a naval hospital are full-time commissary workers, which makes the commissary by far the largest functional unit. The payroll costs for commissary workers alone is from 70 percent to 90 percent of the cost of the food itself. In addition, much time is spent by ward corpsmen and other personnel delivering food to bed patients.

Commissary Operation: The commissary is more a fixed cost or overhead operation than a direct charge. For any individual hospital, commissary costs per patient rise sharply as the patient load drops. Yet the size of the commissary staff varies greatly in relation to the number of rations served per staff worker. The tables showing past performance in the commissary divisions at the hospitals studied indicate these differences (Tables 75 through 79 in Appendix II).

By far the most significant factor is the physical layout of the commissary division. Table 34 shows the effect on the size and number of functional units. The only compact commissary observed was at Houston; but even there the commissary was designed for a 1000-bed hospital, and is currently feeding less than four hundred patients. Houston, with 74 workers in the commissary, could easily handle the job at San Diego, which employs 200 workers.

The commissary at San Diego is the most glaring example of overstaffing caused by poor layout. San Diego is forced to operate two completely separate main galleys. Galley No. 1 is for bed patients (delivery by carts) and special diets, and Galley No. 2 is for ambulatory patients, and staff personnel. Galley No. 1 is too small for handling staff, and ambulatory patients; while Galley No. 2, which is located a considerable distance from the main hospital



buildings has no storage space, and has no facilities for baking and meat-cutting. An additional staff is required for the officers' mess. The physical consolidation of the commissary would show an immediate reduction in staffing requirements of 60 in the main galley, 10 in the officers' mess, 8 in the special diet kitchen, 9 in the bake and meat shops, and 10 in the storeroom. The total of 97 employees is equivalent to over \$175,000 in annual payroll costs. Considerable modification of Galley No. 2 would be required to effect this saving, at a cost of perhaps \$250,000, but this would easily be paid for in less than two years by personnel savings.

Other hospitals have similar problems. Portsmouth operates separate mess lines for patients, staff, and officers, because of poor layout, and the meat and bake shops are a considerable distance from the main galleys. Consolidation here should effect a saving of at least 25 workers. At Great Lakes, the main galley is highly efficient, but the layout is poor for storage facilities. The bake and meat shop and the galley are used for nurses' mess and the dependents' service.

Newport is confronted with a difficult problem as the mess hall is located on the deck above the galley, but they are able to operate with a small complement because only one main galley is used.

Philadelphia's problem is due more to poor utilization of personnel than to bad layout. However, the galleys are not equipped with rotary ovens, which increases requirements by about ten employees.

The five hospitals have a total staff of 680 workers in the commissary divisions, and an annual payroll of over \$1,250,000. The proper consolidation of these facilities would reduce personnel requirements by about 175 workers or well over \$300,000 annually. If other hospitals, such as Oakland and Corona, have similar problems, more than \$1,000,000 in annual payroll would be saved by arranging commissary facilities properly.

Commissary facilities, such as at San Diego, should be consolidated with the general aim of providing all commissary facilities in one central location. Funds for these major alterations should be provided, and the extent of the alterations should be determined by the amount of payroll savings expected.

A survey of commissary facilities should be conducted at all naval hospitals to determine where major alterations are warranted in terms of personnel savings. The survey team should consist of one highly competent commissary officer and one management engineer.

Proposed Standard Staffing: The physical layout of the commissary division is the controlling factor in determining staff requirements. It is not practical, at this time, to set one



standard for all hospitals, but instead a standard must be determined for each hospital.

Past performance statistics (Table 37) show fairly accurately what might be expected at individual hospitals. Houston has the most ideal commissary for a patient load of 1000, and the present staff is considered a typical staffing standard. From the available data, the performance standard shown on Table 36 has been developed.

The proposed staffs for individual hospitals with present typical layout, would be as follows:

TABLE 35  
PROPOSED STAFF REQUIREMENTS FOR INDIVIDUAL HOSPITALS

<u>Patient Load:</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>
Ideal Hospital (from Table 3)	46	59	65	74	81	87
Portsmouth	75	90	100	110	115	
Philadelphia*		70	80	90	95	100
Great Lakes	60	70	80	90		
San Diego			130	140	150	155
Newport	55	65	75	80	85	

\* Does not include personnel for delivering food to wards.

Variations above the standard for the "ideal hospital" are due, primarily, to physical layout.

The staffing standards shown on Table 36 should be adopted for the commissary division. Significant variations from the staffing standards should be investigated to determine how much improvement can be effected by alterations in the physical layout.

Delivering Food to Wards: Ward corpsmen are responsible, generally, for picking up and delivering food to wards. In many cases, the dishes and carts are also cleaned on the wards, although there is no consistency among hospitals in these practices. The work is usually performed by inside patient details.

Some hospitals which are short of ward corpsmen employ civilians for food delivery, particularly where patient details are not available, such as in veterans' or dependents' wards. Philadelphia uses approximately 50 civilians who perform no duty other than working on delivery carts and washing dishes in wards. Dependents' wards generally use maids, with the notable exception of San Diego, which uses six corpsmen full-time on galley duty.

Philadelphia's problem was caused by the high percentage of veteran patients which made it difficult to obtain sufficient patient details. Corpsmen were extremely busy on the heart ward and certain surgical wards. Although corpsmen could not handle the galley work for the noon meal, it is probable that they could do this work for the morning and evening meals. They are handicapped by the lack of dishwashing machines on the wards, whereas other hospitals have a surplus which could be reissued.

San Diego uses about 30 corpsmen full-time on ward galley details. It is extremely doubtful if this practice is justified in view of current corpsmen shortages.

The recommendations for the commissary division typify the importance of patient details in the hospital economy. In hospitals where the veteran patient load is high percentagewise, and where it becomes difficult to obtain sufficient patient details, the cost per patient day may be expected to rise 10 to 20 percent higher than would otherwise be expected.

Civilian maids should perform all ward galley work for dependents' services. In those wards where the lack of patient details and ward corpsmen make full-time galley workers necessary, these workers should be civilian; but this service should be limited insofar as possible to the noon meal (to tie in with a three-shift system). No corpsmen should be used full-time for ward galley details. Dishwashing should be performed on the wards, but the cleaning of the carts should be made the responsibility of the main galley, except where full-time galley workers are employed. All surplus dishwashing machines at naval hospitals should be made available for reissue to hospitals where shortages exist. Staff requirements for full-time ward galley workers should be justified individually for each hospital requiring such workers over the standard established in Table 36.

#### RECOMMENDATIONS:

1. Commissary facilities, wherever practicable, should be consolidated with the general aim of providing all commissary facilities in one central location. The extent of alterations should be determined by the amount of payroll savings expected.
2. An eight-hour day, five-day week should be established at all hospitals employing more than 50 commissary workers.
3. Flexibility in the assignments of commissary workers should be stressed in order to make full utilization of the available manpower. Employees should be shifted from one job to another, if necessary, to avoid waste time.



4. A thorough job analysis should be made of commissary occupations to:
  - a. Describe the positions accurately for purposes of clarifying employment specifications (as for female workers).
  - b. Facilitate proper grade assignment.
  - c. Establish appropriate wage rates, particularly for such positions as chief cook and steward.
5. Where commissary workers are not performing the duties called for by their job titles, corrective action should be taken. Misassignments should be corrected when the impact will be felt the least, i.e., when a general raise in rates occurs, during reductions in force, and by replacements due to turnover. Where absolutely necessary, however, demotions should be effected.
6. One civilian steward should be employed at all hospitals to provide the necessary continuity, to relieve the commissary officer of much of the overload, and to act in his absence. Only the large hospitals would require a chief cook in addition to a steward.
7. The use of corpsmen in the commissary division should be restricted to chief pharmacist's mates and pharmacist's mates, first-class, in supervisory jobs plus those specifically assigned to police mess lines at certain hours. Corpsmen should not be used as storeroom hands, diet kitchen helpers, and office clerks.
8. Civilian maids should perform all ward galley work for dependents' services. No corpsmen should be used full-time for ward galley details. Dishwashing should be performed on the wards, but the cleaning of the carts should be the responsibility of the main galley, except where full-time galley workers are employed in the wards.
9. The special diet kitchen should be administratively responsible to the commissary officer rather than the chief nurse.
10. Separate nurses' messes should not be operated for less than 40 nurses, or where the staff required would be more than one commissary worker for five nurses.
11. The method of charging maid service on the Expense Analysis Register accounts should be clarified. Dining room duties which some maids may perform as an incidental portion of

their maid duties for staff quarters should be charged against the account "E-303 Staff Quarters". The commissary division, account "E-310 Commissary", should be charged only for cooks, mess attendants, etc.; never for maid service.

12. Forms and records procedures of the commissary division should be revised and standardized. The Bureau, in conjunction with the Commissary Department of the Hospital Corps School, Bethesda, should undertake the task of standardization.
13. The staffing standards shown on Table 36 should be adopted. Significant variations from the staffing standards should be investigated to determine how much improvement can be effected by alterations in physical layout.



TABLE 33

## DISTRIBUTION OF CIVILIAN NON-IVB WORKERS BY GRADES IN THE COMMISSARY DIVISIONS

	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>	<u>Houston</u>	<u>Norfolk</u>
Steward	1		2	3			
Chief Cook	1	1	3	1	1	1	1
1st Cook	11	3	6	8		4	5
Cook	17	42	8	36	15	11	13
Ass't Cook	12	6	4	3			6
Pantrymen	6			12		3	2
Ch. Mess Attendant		1	3			1	
Chief Baker	50	123	43	90	30	44	88
Baker	2		3	9	3	1	3
Chief Meat Cutter			1				
Meat Cutter	1	4	2	6	2	1	3
Ass't Meat Cutter	1	4					
General Helper			2				
Maid					2		
Civilian Non-IVb	102	184	78	169	53	68	111

TABLE 34

## DISTRIBUTION OF STAFF BY FUNCTIONAL UNITS IN THE COMMISSARY DIVISIONS

	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>	<u>Houston</u>	<u>Norfolk</u>
Office & Storeroom							
Civ. IVb	2	3	3	3	1		
Civ Non-IVb	14	1	6	8	1	8	10
Main Galley & Mess	50	67	44	48 ; 69	30		
Officers' Mess	9	15	5	20	6		
Nurses' Mess		20	11		4		
Special Diet Kitchen	12	27	4	14	6		
Night Cooks	2	2	2	2	1		
Meat Shop	4	6	4	6	2		
Bake Shop	4	5	4	11	3		
Carts	7	47					
Total Staff	112	205	100	200*	63	74	131
Rations Served (est.)	1000	1800	1250	2000	900	600	1000
Staff per ration	1.12	1.14	0.80	1.00	0.70	1.23	1.31
Ration of Commissary Workers to total staff	18%	20%	13%	21%	15%	18%	19%

\* Plus 30 galley corpsmen.



TABLE 36

## PROPOSED STANDARD STAFF REQUIREMENTS FOR COMMISSARY DIVISION

<u>Patient Load</u>	<u>Rations Per Patient</u>	<u>Average Daily Ration</u>	<u>Rations Per Staff</u>	<u>Total Staff Required</u>
200	1.50	300	0.100	30
400	1.45	580	0.080	46
600	1.40	840	0.070	59
800	1.35	1,080	0.060	65
1,000	1.35	1,350	0.055	74
1,200	1.35	1,620	0.050	81
1,400	1.35	1,890	0.046	87
1,600	1.35	2,160	0.043	93
1,800	1.35	2,430	0.040	97
2,000	1.35	2,700	0.037	100

\* Staff includes military personnel for galleys, mess hall, officers and nurses' mess, storeroom, office, bakery and meat shop, etc. This does not include personnel used in delivery of food to wards or dishwashing on wards.

TABLE 37

STAFF EMPLOYED PER RATION IN COMMISSARY DIVISIONS - PAST PERFORMANCE  
(Figures in parentheses are total staff)

<u>Date</u>	<u>Portsmouth</u>	<u>Phila.</u>	<u>Gr. Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	0.084	0.090	0.040	0.065	0.079
Feb	.091	.101	.048	.065	.084
Mar	.096	.104	.055	.072	.088
Apr	.098	.107	.053	.074	.105
May	.100	.107	.052	.084	.122
June	.102	.116	.053	.092	.111
Jul	.088	.123	.056	.093	.117
Aug	.073	.125	.059	.107	.084
Sep	.105	.111	.065	.108	.081
Oct	.111	.111	.075	.100	.074
Nov	(460 Patients)	.107	.054	.097	.079
Dec		.118	.069	.091	.092
<u>1947</u>					
Jan		(1220 Patients)	.076	.095	.082
Feb			.080	.094	.071
Mar			(300 Patients)	.099	.071
Apr				(1350 Patients)	.067 (650 Patients)
<u>Average Daily Ration</u>	<u>Portsmouth</u>	<u>Phila.</u>	<u>Gr. Lakes</u>	<u>San Diego</u>	<u>Newport</u>
500 - 1000					.084 (67)
1000 - 1500	0.108 (117)	0.078 (97)			(.100) (127)
1500 - 2000	.093 (175)	.112 (210)	.054 (102)		.079 (124)
2000 - 2500	.090 (200)	.116 (250)	.070 (155)	.096 (215)	
2500 - 3000	.077 (205)	.120 (275)	.059 (165)	.093 (280)	
3000 - 4000	.060 (225)	.094 (300)	.056 (195)	.088 (330)	
4000 Plus	.044 (240)	.068 (285)	.050 (220)	.069 (400)	





## SECURITY AND MAA DIVISION

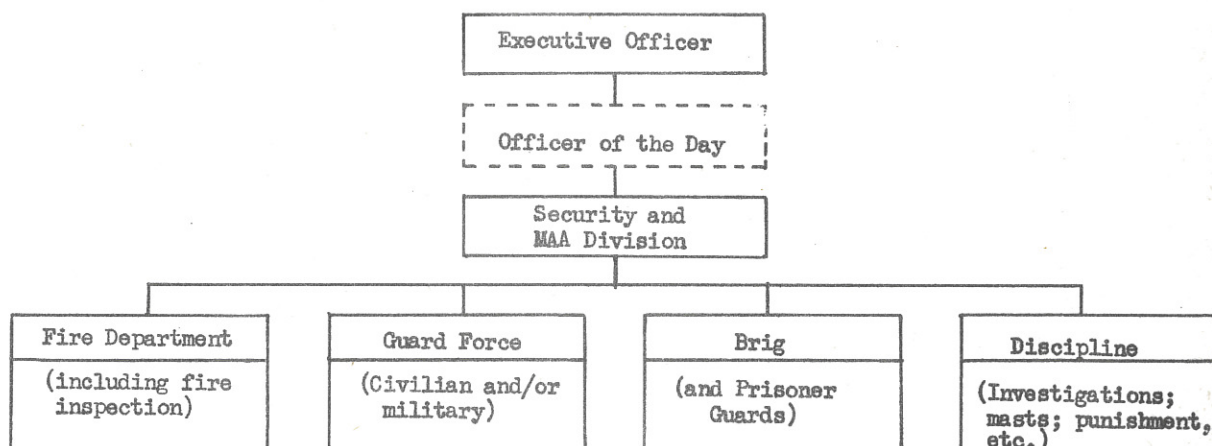
### ORGANIZATION

The organization and function of the master-at-arms force show the least consistency, and present the most confusion of any of the major organizational units. At one time, apparently, the master-at-arms was responsible to the maintenance officer. When the change was made in the Manual of the Medical Department, functional reallocations were not completed.

For example, the Manual still states, "The maintenance officer shall have charge of all maintenance and security." The word "security" is ambiguous and is probably retained as one of the former responsibilities of the maintenance officer. Conversely, the master-at-arms now performs duties which were formerly under the maintenance officer, such as directing cleaning details. Also, in line with paragraph 16A22.3 of the Manual, he performs duties which are normally under the jurisdiction of the Hospital Corps detail desk.

The supervisor of the MAA force is variously designated the master-at-arms, the legal officer, the security officer, and the provost marshal. A strict interpretation of the Manual of the Medical Department indicates jurisdictional conflict with both the maintenance officer and the personnel officer.

Proposed Organization for the Security and MAA Division: In order to consolidate all security and disciplinary functions, the following organization is proposed:





The present organization chart shows the master-at-arms responsible only to the officer of the day. Hospitals do not follow such an organizational pattern between 0800 and 1630.

Large hospitals should have an officer in charge of the security and MAA division. In small hospitals a competent chief pharmacist's mate would probably be adequate, with assistance from the executive officer in the more difficult problems. A billet should be established for a Hospital Corps officer as the security and disciplinary officer in large hospitals (over 800 patients), and also in medium-sized hospitals (400 to 800 patients) which have a fire department and civilian guard.

Functions: No two hospitals follow the same pattern and none include all the following functions under the master-at-arms:

1. Guarding and working prisoners.
2. Processing staff and patient disciplinary cases.
3. Acting as barracks MAA.
4. Supervising the civilian guard force.
5. Supervising the fire department.
6. Assigning patient details.
7. Responsibility for staff and patient liberty.
8. Responsibility for cleanliness of certain building areas.

Patient Details: The assignment of patient details is presently both an organizational and personnel utilization problem. In most cases, the military personnel office has no control over the assignment of patient details, yet this office is in the best position to know where manpower is most needed, and should be the most qualified technically to assign personnel. The master-at-arms has often been criticized for using patient details indiscriminately. Further, there is considerable overlapping of responsibility between the maintenance division and the MAA force in regard to the cleanliness and maintenance of grounds and buildings, especially when patients are used to assist with these functions.

The administration and assignment of patients to work details should be the responsibility of the rehabilitation desk in the military personnel office in order to obtain proper coordination with the assignment of enlisted personnel by the Hospital Corps detail desk. (See section of report on "Personnel Division.")

Patients and staff assigned to house-keeping and grounds maintenance details should be under the direction of the maintenance officer. Appropriate military supervision should be provided.

Liberty: The liberty function is usually the responsibility of the MAA, primarily because



he has charge of working details. If the above recommendations are effected, liberty would be a logical function of the personnel division. The basic policy of "no work, no liberty" can be applied by the patient rehabilitation desk. Responsibility for staff liberty by the master-at-arms has often caused misunderstanding, and certainly results in additional work. Then too, a more disinterested office should make the investigation of breaches of discipline involving liberty. Liberty should be a personnel function, rather than a responsibility of the disciplinary office.

Discipline: There is a large volume of time-consuming work regarding discipline, masts, etc., for both patients and staff. At many of the hospitals, because of the tact and good judgment required, most of this work is performed by the administrative officer. As a result, he is very often unable to devote sufficient time to supervising the administrative divisions. The effective execution of security and discipline functions requires high quality supervision, and should be a responsibility of the security and disciplinary officer.

Prisoner Guards: Portsmouth, Philadelphia, and Newport are forced to use hospital corpsmen to guard and chase prisoners. A detachment of 28 Marines is assigned to the San Diego naval hospital to guard prisoners; but the gate guard force is entirely civilian. Civilians are used at the gates despite the fact that 28 Marines assigned to the hospital are more than adequate for prisoner and brig guard duty. The executive officer at San Diego informed the survey team that orders forbade the use of Marines as gate guards. The main training station at Great Lakes provides a Marine gate guard force for the hospital.

The Bureau should make every effort to obtain Marines for guarding and chasing prisoners. The policy pertaining to the availability of Marines for guarding prisoners and standing gate watches should be clarified.

#### WORK MEASUREMENT

Statistics available for the past performance of the MAA force show considerable inconsistency (Table 39). However, from these figures and from discussions at the hospitals, the staff requirements listed in Table 38 were arrived at on the premise that functions such as enlisted details and the issuance of liberty cards would be performed by other units. The proposed personnel requirements include an adequate staff for guarding prisoners.



The number required at various patient loads, particularly for the gate watch and the fire department, depends to a great extent on local factors such as physical layout and the proximity of other naval activities. The staffing requirements shown should be considered as a typical guide rather than a fixed standard.

Civilian Guard Force: At two of the hospitals, the civilian guard force was not under the jurisdiction of the MAA. The result is a split responsibility for security, particularly when both military and civilian guards are used. The civilian guard force should be responsible to the security and disciplinary officer.

Portsmouth and Philadelphia are entirely dissatisfied with the quality of performance of the civilian guards. Conversely, San Diego prefers civilian to Marine guards. It is obvious, however, that the caliber of the civilian guard force at San Diego is far superior to that of the other hospitals.

It is doubtful if any gate guard force can entirely control pilferage. At best, the effect is psychological. The problem at Portsmouth and Philadelphia is that the individual guards are lax, undisciplined, and incompetent.

The hospitals claim they are obstructed by Civil Service regulations in their effort to develop a competent guard force, particularly since wartime demands forced a lowering of the hiring standards for these positions. Observation indicates that this is only partially true. The hospitals do not specify hiring requirements adequately at time of recruitment, do not investigate prospective employees referred by the Commission, and, for the most part, do not demand full performance on the job. If the guards do not meet performance standards, they should be released, but a man should not be given an efficiency rating of "excellent" or "very good" and then be released for poor performance. Hospitals have often been rebuffed in the past in their efforts to release poor employees because of a lack of knowledge of personnel regulations, and are reluctant to repeat the process. The problem will be solved only by effective supervision, good personnel practice, and a knowledge of civilian personnel regulations. The effective use of civilian guards at San Diego clearly demonstrates that they can be effective when handled properly.

Fire Department: The fire departments at Portsmouth and San Diego are responsible to the maintenance officer. At Philadelphia a fire watch of four hospital corpsmen is under the master-at-arms. At Great Lakes the hospital fire department is solely under the cognizance of the fire department at the training station. The fire-fighting service at Newport is



provided by the training station and no full-time unit exists at the hospital.

Fire inspection and fire-fighting is part of the overall security of a hospital, and its activities are closely related to the work performed by the master-at-arms force. For example, night security patrols include fire prevention inspection as well as general police security. Much of the work performed by the fire department is preventive inspection work involving the maintenance department. It is not generally considered good practice to have an inspector administratively responsible to the head of the department which he inspects.

The fire department should report to the security and disciplinary officer rather than the maintenance officer, and fire-fighting should be considered a security function rather than a maintenance function. The decision as to whether or not a separate fire department is necessary for a hospital has generally been made by the medical officer in command and the district headquarters. However, there is apparently little consistency as to the method of determining what fire-fighting facilities are required.

Newport, constructed essentially the same as Great Lakes and Portsmouth, has no fire department of its own but uses the fire department from the main training station, about five minutes away. Great Lakes has a fire department, although the fire department at the main training station is no further away than Newport. At Portsmouth, the fire department at the navy shipyard and the city fire department are further away. There is a small fire watch at Philadelphia, which uses the fire-fighting services of the navy shipyard and the local fire department. San Diego has the largest civilian fire department of all hospitals, but its buildings are probably the most fireproof.

A further investigation should be made at hospitals such as Great Lakes and San Diego to determine if adequate service could be provided by the local city fire departments and larger naval activities in order to eliminate independent hospital fire-fighting service. It is believed that suitable arrangements can be worked out with the local facilities for weekly fire drills.

The following is the personnel complement at the three hospitals which maintain individual fire departments:

<u>Portsmouth</u>
CFC-9 -- 1
CFC-7 -- 2
CFC-6 -- 2
Corpsmen -- 9
Total 14

<u>Philadelphia</u>
Corpsmen -- 4

<u>San Diego</u>
CFC-10 -- 1
CFC-8 -- 2
CFC-7 -- 3
CFC-6 -- 7
Total 13



At Portsmouth and Philadelphia the corpsmen detailed to fire fighting performs no other duty. Civilians should be employed where full-time fire-fighters are necessary.

Considerable inconsistency exists in the application of pay grades for civilian fire-fighters, both at San Diego and Portsmouth, and should be corrected.

Civilian fire-fighters work three, 24-hour days per week, receiving pay for 16 hours of each 24-hour shift, the remaining eight hours being considered sleeping and eating time for which no pay is received. They therefore are paid for a 48-hour week, eight hours of which are overtime and paid at time-and-a-half. As a result, their salary ranges from \$3500 to almost \$5000 per year. The average fire-fighter receives about \$3800, and the average chief fire-fighter about \$4700.

The "take-home pay" earned by fire-fighters is far in excess of that for other trade workers. For example, the maximum pay for a carpenter is about \$2900 a year. This situation has caused considerable criticism, as the average civilian employee believes that firemen have the easiest job in the hospital.

To pay only one group of employees overtime consistently is not a sound personnel practice. Yet, to provide for the maximum utilization of personnel and complete fire protection, some variant of a 24-hour watch system must be employed. From the management standpoint, overtime pay is highly inefficient since 52 hours pay for 48 hours work adds considerably to the cost of operating a fire department.

The present operating schedule is called the two-platoon system. Actually, three platoons are necessary under the present system to provide for week-end coverage. Therefore, the present system offers no real advantage over the three-platoon method. One of the possibilities suggested was the use of fire-fighters on three 24-hour days one week and two, 24-hour days the next week, providing a total of 80 paid working hours for the two-week period. Eight hours over the 40 hours in the first week must be paid for on a time-and-a-half basis in accordance with a Controller General's decision. The firemen would then receive pay for a total of 84 hours in two weeks, as contrasted with 104 hours as at present.

If this system were utilized, half of the overtime pay would be saved for the hospitals. It would be sufficient not only to pay for the one or two additional firemen required, but would also result in a net saving of \$1000 to \$3000 per year. For example:

<u>Present Method</u>			
<u>Firemen Now Employed</u>	<u>Base Pay (Est.)</u>	<u>With Overtime (48-hr week)</u>	<u>Annual Payroll</u>
6	\$2920	\$3800	\$22,800
12	\$2920	\$3800	\$45,600

<u>Proposed Method</u>					
<u>Firemen Required</u>	<u>Base Pay</u>	<u>With Overtime (4 hrs in 2 wks)</u>	<u>Annual Payroll</u>	<u>Saving</u>	<u>% Saving</u>
7	\$2920	\$3070	\$21,490	\$1300	5.7
14	\$2920	\$3070	\$42,980	\$2600	5.7

In addition to the substantial monetary savings, there would be more fire-fighters available for emergency duty and sufficient replacements for men on annual or sick leave.

#### RECOMMENDATIONS

1. A security and MAA division should be established in place of the chief master-at-arms, which appears on the current organization chart in the Manual of the Medical Department. The division should be responsible to the executive officer during regular working hours and to the officer of the day during the remainder of the day.
2. A billet should be established for a Hospital Corps officer as security and disciplinary officer in large hospitals (over 800 patients), and in medium-sized hospital (400 to 800 patients) which have a fire department and civilian guards. He shall be in charge of the security and MAA division. A competent chief pharmacist's mate should be adequate in small hospitals, with assistance from the executive officer in the more difficult problems.
3. The security and MAA division should be responsible for the following functions:
  - a. Supervision of the guard force; military and civilian.
  - b. Supervision of the fire department, including fire inspection.
  - c. Administration of brigs and supervision of prisoner guards.
  - d. Maintenance of discipline (investigations, masts, punishments).
4. The administration and assignment of patients to work details should be the responsibility of the Hospital Corps detail desk in the personnel division rather than the security and MAA division, so that the necessary coordination with the assignment of enlisted staff



personnel can be effected. (See section of report on "Personnel Division.")

5. Patients assigned to cleaning and grounds maintenance details should be under the direction of the maintenance officer rather than the master-at-arms.
6. The administration of leave and liberty should be a function of the personnel division.
7. The Bureau should make every effort to obtain Marines for guarding prisoners. The policy pertaining to the availability of Marines for guarding prisoners and for gate watches should be clarified.
8. Rigid employment and performance standards should be established for civilian guards. Where performance standards are not met, the individual guard should be released. The quality of performance of civilian guards can be improved by stricter supervision and the employment of better personnel practices.
9. A study should be made at all naval hospitals to determine if fire-fighting facilities provided by the local city departments and nearby naval activities would be sufficiently adequate so that independent fire departments at the hospitals can be eliminated.
10. All full-time fire-fighters should be civilian employees.
11. The 48-hour week for fire-fighters should be discontinued. Shift schedules should be arranged to provide for three 24-hour days in one week and two 24-hour days the following week.
12. Nurses and ward corpsmen should be trained in the use of fire-fighting appliances.
13. A review of the job description of civilian guards and fire-fighters should be made to correct discrepancies in grades.
14. The staffing standards shown on Table 38 should be adopted.

TABLE 38

## PROPOSED STANDARD STAFF REQUIREMENTS FOR SECURITY AND MAA DIVISION

<u>Patient Load</u>	<u>Military Staff per Patient</u>	<u>Military Staff* Required</u>	<u>Gate Watch** (Civilian &amp; Mil.)</u>	<u>Fire Dept.**</u>
200	.030	6	(6)	(7)
400	.023	9	6 (1 per shift)	7 (2 per watch)
600	.020	12	6	7
800	.019	15	9 (2 on day shift)	10 (3 per watch)
1000	.018	18	12 (2 per shift)	10 (3 per watch)
1200	.018	21	12	10
1400	.017	24	15 (3 on day shift; 2 on p.m. and night)	10
1600	.017	27	15	13 (4 per watch)

\* Military staff includes (except for 200 patient load) military force for guarding and chasing prisoners.

\*\* Gate watch and fire department requirements are typical and subject to considerable change due to local circumstances. Justification should be made by the individual hospitals.



TABLE 39

## PAST STAFFING OF MASTER-AT-ARMS FORCES

Date	PORTSMOUTH			PHILADELPHIA			GREAT LAKES		SAN DIEGO			NEWPORT		
	Mili. Pers.	Civil. Guard	Mil.Pers. per Patient	Mili. Pers.	Civil. Guard	Mil.Pers. per Patient	Mili. Pers.	Mil.Pers. per Patient	Mili. Pers.*	Civil. Guard	Mil.Pers. per Patient	Mili. Pers.	Civil. Guard	Mil.Pers. per Patient
<u>1946</u>														
Jan	47		.040	34	10	.011	101	.014	70	49	.016	20	14	.017
Feb	31		.026	37	10	.014	102	.017	55	51	.014	15	14	.013
Mar	21		.021	43	11	.017	73	.015	73	49	.021	24	13	.023
Apr	14		.014	30	11	.012	98	.023	71	51	.023	20	14	.023
May	13		.014	28	11	.012	70	.018	76	54	.032	23	13	.031
Jun	12	11	.014	36	11	.015	53	.016	60	52	.031	13	9	.021
Jul	10	13	.012	34	11	.018	46	.017	56	48	.032	9	8	.015
Aug	13	13	.021	26	11	.017	87	.041	57	46	.035	12	8	.022
Sep	19	13	.032	26	9	.018	54	.033	46	41	.029	11	7	.018
Oct	15	13	.028	28	9	.020	45	.036	46	25	.030	10	6	.017
Nov	11	13	.024	25	9	.019			43	23	.030	10	6	.018
Dec				15	11	.012	16	.016	43	23	.032	7	6	.014
<u>1947</u>														
Jan				13	11	.011	16	.017	43	24	.030	5	6	.009
Feb				16	11	.013	22	.025	42	25	.030	5	6	.008
Mar									43	25	.032	5	6	.008
Apr												5	6	.008

\* Including Marine detachment

## STAFF QUARTERS

Nurses' Quarters: Civilian maids assigned to the nurses' quarters generally perform cleaning duties, although they may be used for part-time duties in the nurses' mess. There is no consistency among hospitals in regard to the number of maids employed in the nurses' quarters.

Maids are frequently charged to either the commissary division or maintenance division for cost analysis purposes. Personnel titled "maid" should not be carried by either of these divisions. Where the major portion of a person's duties are in the nurses' mess, she should be titled "mess attendant" and charged to staff quarters.

Staff Officers' Quarters: The policy of using civilian workers in officers' quarters for the maintenance of government property and equipment rather than for personal service is followed closely, if not exactly. Two of the hospitals title these workers "maids", two others have "laborers", and the fifth a "head laborer". The title of "maid" should be avoided for personnel employed for this purpose.

A consistent policy should be established regarding the use of both civilian and enlisted personnel in the maintenance of staff officers' quarters.

Hospital Corps Quarters: One or more barracks master-at-arms are assigned to the Hospital Corps quarters. Two hospitals fail to charge these services to the Expense Analysis Register, "Account E-303 - Staff Quarters."

### RECOMMENDATIONS:

1. A standard complement for maids should be established in the following ratio:

Nurses	20	30	40	50	60	70	80
Maids	$\frac{2}{3}$	$\frac{3}{3}$	$\frac{4}{4}$	$\frac{5}{4}$	$\frac{6}{5}$	$\frac{7}{6}$	$\frac{8}{7}$

2. Where a major portion of an employee's duties are in the nurses' mess, she should be titled "mess attendant" (not "maid") and charged to staff quarters.
3. A consistent policy should be established regarding the use of both civilian and enlisted personnel in the maintenance of staff officers' quarters (excluding nurses' quarters).
4. The title of "Maid" should be avoided for personnel employed for this purpose.
5. Current instructions should be followed concerning the method of charging personnel to staff quarters.





## MEDICAL LIBRARY

Each hospital maintains a medical library for the use of Medical Corps, Hospital Corps, and Nurse Corps officers. Without exception the libraries are conveniently located, and physical facilities are adequate. Professional librarians are available at three of the five hospitals to perform technical library work, and to service authorized personnel. Enlisted personnel, including chiefs, provide service at the other two hospitals.

It is estimated that at least \$150,000 is expended for civilian and military personnel costs alone in operating medical libraries. This figure comprises only a fraction of the total maintenance expenses. The Medical Department should therefore make every effort to assure that the library at each hospital is fully utilized. At present medical officers are making very little use of available facilities. The volume of activity is so small that the library could almost be considered as an unnecessary expense. Two of the most apparent reasons for this situation are that there is not a sufficient number of recent medical books on the shelves, and that many officers are not fully aware of the available service.

### METHODS AND PROCEDURES

As stated above, there is a definite need for more recent medical books. Individual hospitals are not permitted to obtain these books through open purchase. Every librarian contacted stated that after a requisition was submitted, several months elapsed before part of the order was filled, and in many cases, a considerable number of the requested books were refused. It is important that the medical staff be well informed, and that the library be maintained as a current adjunct. If libraries are to be retained in any form, the Bureau should make every attempt to assure that hospitals receive authorized publications as soon as possible after they are requested.

A more rigid loan policy should be established to reduce the number of lost medical books. Although books are charged out to individuals, the various services usually retain several volumes pertaining to their particular specialty on an indefinite loan basis. At present all of these books are charged to a medical officer. He is responsible for the safe-keeping of these books, and should return them upon request or when transferred to other duty. Although rules are established for the return of library books, there is no procedure established to force medical officers to replace or pay for books if they are not returned. As a result, many expensive medical publications have been removed, and not returned to the library. In



order to correct this situation, every book that is on loan should be charged to a specific medical officer and if not returned, appropriate action should be initiated to insure reimbursement or replacement of the lost hospital property.

The medical library should be located adjacent to the recreational (crews) library in order to eliminate the need for two professional librarians in each hospital. Even in the largest hospitals, the volume of activity in the medical library does not actually warrant the full-time services of one professional employee. However, it is considered essential that a qualified librarian maintain close supervision to insure satisfactory operation. In addition to the librarian, each library employs from one to three part or full-time assistants. One professional librarian could direct both libraries' activities if they are located adjacent to each other or in the same immediate area. The staffs would then be more interchangeable, the problem of adequate personnel coverage would be less difficult, and work on such large projects as inventories would be facilitated.

#### RECOMMENDATIONS

1. The medical library and recreational (crew's) library should be located adjacent to each other, or in the same immediate area.
2. One professional librarian should supervise both libraries. The volume of activity does not warrant separate librarians for each library.
3. The Bureau should take action to fill commanding officers' requests for authorized books more properly. There is not a sufficient number of recent medical books on the shelves.
4. A more rigid loan policy should be established to reduce the number of lost medical books. Personnel who fail to return books to the library should pay for replacing them.

## OFFICE SERVICES

Miscellaneous office services, including telephone, communication, mimeograph, photostat, office supply, and messenger activities, are scattered throughout the hospital and located without evidence of advance planning. Apparently the main consideration has been to use any available space without regard for a central location which is easily accessible to all hospital activities. The teletype equipment and operators, for example, would function best in the immediate vicinity of the information desk, so that messages will be received and relayed without delay.

At the present time these service units operate quite independently, with little supervision or control exercised by any office. At one hospital, for example, the mimeograph service was under the finance division. The finance officer was not particularly interested in this function, and the enlisted man in immediate charge of the office operated independently as he saw fit. In order to establish organizational unity and obtain better results, all office service functions should be consolidated in one unit, which should be responsible to the administrative officer and be located near his office. All requests for office services from the operating activities should channel through this unit. This method will result in better administrative control of office service personnel and a more complete utilization of the services provided by the hospital.

In general, the messenger service at hospitals needs improvement. Effective use of patients as messengers will save much time and effort now being expended unnecessarily by corpsmen and civilian clerks. It is not necessary to employ civilian messengers or assign staff enlisted personnel full-time as messengers. Complete coverage can be afforded operating divisions through the centralized assignment and control of messengers as an office service function.

The innumerable local forms currently in use in the naval hospitals are varied in size, content, and general utility. There is little control exercised to keep the volume and variety at a minimum. These forms were developed to meet specific needs at given times, and additions to or deletions from them have been made from time to time as conditions changed. Consequently, for the most part, the records and forms in naval hospitals have developed without central planning or control, either within the hospital or by the Bureau. One person often designed a form to meet his needs without taking into consideration how such data would fit into the total records procedure or the procedure



of another office requiring identical data. This practice has resulted in an excessive number of forms, poorly designed forms, and non-standardized forms.

All current local forms should be reviewed to determine if they are necessary or if they can be eliminated or consolidated with other forms. Duplication of information on forms and the accumulation of surplus stock should be avoided. In addition, local forms should bear hospital control numbers, more attention given to design and content, and usage rates should be established. As part of the forms control function, liaison should be maintained with the Bureau and the district printing offices to promote better control of printed forms.

Much valuable hospital space is ill-used or wasted. Careful advance planning and closer attention to the control and anticipated use of office space, in particular, is needed. Office services is the logical office to conduct space studies and plan and accomplish physical moves for the improvement of hospital operation.

The telephone service, which presents several operating problems, is discussed in the succeeding section of the report.

#### RECOMMENDATIONS

1. Office service functions including telephone, communication, mimeograph, photostat, office supply, and messenger activities, should be consolidated in an organizational unit entitled "Office Services", which should be responsible to the administrative officer.
2. Office services activities should be centrally located to facilitate the servicing of operating divisions.
3. All requests for office services from the operating activities should channel through this unit.
4. Ambulatory patients should be used as messengers in lieu of full-time civilian messengers or staff enlisted personnel.
5. A forms design and control system should be established for better utilization of local forms.
6. All current local forms should be reviewed to determine if they are necessary or if they can be eliminated or consolidated with other forms.

7. The control of space, particularly for administrative offices, should be a function of office services. Careful advance planning and continuous analysis concerning the use of space is necessary.



## TELEPHONE SERVICE

Portsmouth, Philadelphia, and San Diego hospitals operate local telephone exchanges. Telephone service for the Great Lakes hospital is provided by the training station, but the hospital pays for two telephone operators as its prorated share. At Newport the training station provides telephone service for the hospital without charge.

### ORGANIZATION

At most hospitals the telephone service is a separate organizational unit responsible to the administrative officer. It is not shown on many hospital organization charts, however, including the one in the Manual of the Medical Department. Since the telephone service is widely used by all activities in the hospital, it is recommended that it be consolidated with the other office services in the proposed new office services unit. Physically, the telephone office would continue to be located near the officer of the day's office.

### PERSONNEL

The distribution of operators in the three hospitals having a telephone exchange is as follows:

<u>Portsmouth</u>		<u>Philadelphia</u>		<u>San Diego</u>	
<u>Grade</u>	<u>Number</u>	<u>Grade</u>	<u>Number</u>	<u>Grade</u>	<u>Number</u>
CAF-6	1	CAF-2	6	CAF-7	1
CAF-4	1			CAF-6	1
CAF-3	6			CAF-4	1
CAF-2	4			CAF-3	2
				CAF-2	10

There are obviously inconsistencies in the classification of telephone operators. Excess supervisory grades exist as a carryover from wartime operations. All telephone operator job descriptions should be reviewed to correct discrepancies, and to provide a uniform organization and grade structure.

### WORK MEASUREMENT AND STAFF REQUIREMENTS

Since telephone service is an overhead operation, no effort has been made to correlate minimum personnel requirements with the workload. It has been determined that, with an automatic system, six telephone operators are adequate to cover all shifts and can handle all

calls. In general, two operators should work on the day shift (0800 - 1600), one from 1600 to 2400, and one from 2400 to 0800. The remaining two operators are necessary for a full seven-day coverage, and as replacements for personnel on annual and sick leave.

Portsmouth and San Diego are currently employing two telephone operators each on the second and third shifts. Neither hospital, however, requires more than one operator for each of these shifts to handle the volume of work.

Rest room facilities should be provided immediate adjacent to the telephone office so that the operators, particularly the one on each night shift, will be absent from the switch board only a minimum of time.

Both Portsmouth and San Diego use manually operated systems. The cost, if any, to convert to an automatic system is inconsequential in comparison with the payroll savings. Further, neither Portsmouth nor San Diego believe there is any advantage to the personal service offered by a manually operated system. Such service can be provided just as well, when necessary, with an automatic system.

#### RECOMMENDATIONS

1. The telephone service should be consolidated with the other office services in the proposed new office services unit.
2. All job descriptions for telephone operator jobs should be reviewed to correct discrepancies and to provide a uniform organization and grade structure.
3. Excess supervisory grades in the telephone service should be eliminated.
4. No more than one telephone operator should be employed on the second and third shifts.
5. Manual systems in all hospitals should be converted to automatic systems.
6. Rest room facilities should be provided immediately adjacent to the telephone office. When it is necessary for the telephone operator to be absent for a short time, relief corpsmen from the officer of the day's office should be assigned to the switch board.





VI PROFESSIONAL SERVICES





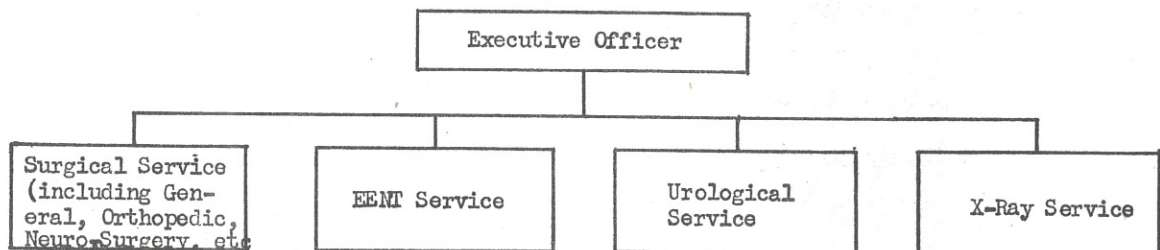
## SURGICAL SERVICE

### ORGANIZATION

The surgical service usually consists of general surgery, orthopedic surgery, neurosurgery, plastic surgery, and such units as the main operating room, central surgical supply, and the office of the chief of the surgical service. In some hospitals, the EENT service, urological service, and X-ray service are administratively responsible to the chief of the surgical service, but, in effect, operate as independent units. Whether or not these units operate independently, or as part of the surgical service, depends primarily on the rank and experience of the senior medical officer of the particular service.

It is recommended that the chiefs of all professional services report directly to the executive officer for administrative as well as professional services. If the administrative officer relieves the executive officer of many of the administrative duties which the latter is now performing, as is recommended in Section II of this report, the executive officer will have sufficient time to handle both technical and administrative matters pertaining to the professional services.

The organizational relationship between the executive officer and the chief of the professional services would be as follows:



### PERSONNEL

The principle personnel problem is the shortage of trained employees, which is caused partially by continual turnover. Hospital officials are almost unanimous in their opinion that the tour of duty of operating room technicians should be increased, particularly since the use of civilian workers in the operating room is considered impractical.



Central Surgical Supply: Three hospitals used nurses in the central surgical supply unit, while two do not. It is not necessary to have a nurse supervisor in central surgical supply. A competent chief pharmacist's mate could perform all work required in this unit.

#### METHODS AND PROCEDURES

Operating Room Logs: The method of keeping operating room logs is almost identical in all the hospitals. Some hospitals, however, do not include operations performed by the EENT service and the urological service in the Report of Surgical Operations, NAVMED-P. The information contained in this report should be uniform for all hospitals.

Central Surgical Supply: It is generally difficult to determine the proper physical and organizational location of central surgical supply units. If possible, surgical supply should be located immediately adjacent to the pharmacy, laboratory, or other unit which ward corpsmen visit daily, in order to conserve time in obtaining items required by the wards. In smaller hospitals, personnel savings can be effected if surgical supply is consolidated with another unit. The most logical place is the main operating room, provided no traffic problem is created. The pharmacy has also been suggested. In the final analysis the problem must be solved locally upon consideration of the physical layout and other pertinent factors.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

Operations per Month: The statistics indicate that the percentage of surgical patients is between 35 and 40 percent of the total patients. Operations per patient, per month at any one hospital is very consistent, and the variation rarely exceeds 15 percent. The variation from the average among the several hospitals is not more than 20 percent (Table 42). The volume of operations per patient, per month is influenced by the number of veteran patients.

A fairly reliable expectancy of number of operations per patient, per month can be determined. Statistics for the most recent months show that 0.22 operations can be considered adequate for staffing purposes. This figure is probably somewhat high, but should rarely be exceeded by more than 15 percent.

Operations Performed per Employee per Month: Statistics on the number of operations performed per month, per operating room worker (except medical officers) show little consistency among hospitals (Table 41). However, sufficient information is available to arrive

at a reasonable expectancy of staff performance.

Table 40 shows the proposed standard staff requirements based on an expectancy of 0.22 operations per patient, per month, and performance of from 10 to 24 operations per employee, per month, depending on the patient load. On the basis of Table 40 savings which might be expected are as follows:

<u>Hospital</u>	<u>Excess Employees</u>	<u>Payroll Savings</u>
Portsmouth	2	\$ 4,000
Philadelphia	12	24,000
Great Lakes	4	8,000
San Diego	0	0
Newport	- 1	(-) 2,000
		\$ 34,000

Based on the above table, if the proposed staffing standards are employed at all naval hospitals, the anticipated total savings would be approximately \$150,000.

#### RECOMMENDATIONS

1. Organizationally, the surgical service should include general surgery, orthopedic surgery, neuro-surgery, plastic surgery, etc.
2. The chiefs of all professional services should report to the executive officer for both technical and administrative matters. The EENT, urological, and X-ray services should not report administratively to one officer (chief of the surgical service) and technically to another (executive officer).
3. The tour of duty of operating room technicians should be increased to reduce the training problem.
4. Nurses in the central surgical supply should be replaced by chief pharmacist's mates.
5. The Bureau should issue instructions to clarify what EENT and urological operations should be reported on the Report of Surgical Operations, NAVMED-P.
6. The central surgical supply unit should be located so as to conserve the time of ward corpsmen. Where possible, in small hospitals, these functions should be consolidated with some other unit, such as the main operating room.
7. The proposed standard staffing requirements shown on Table 40 should be utilized.



TABLE 40

PROPOSED STANDARD STAFFING REQUIREMENTS FOR MAIN OPERATING ROOM  
(Performance Standard)

<u>Patients</u>	<u>Operations per Patient</u>	<u>Operations (MOR)</u>	<u>Operations per Staff</u>	<u>Operating Room Staff Required</u>	<u>Central Surgical Supply Staff</u>	<u>Total Staff Required</u>
200	.22	44	10	5	1	6
400	.22	88	15	6	2	8
600	.22	132	17	8	3	11
800	.22	176	18	10	3	13
1000	.22	220	19	12	4	16
1200	.22	264	20	14	4	18
1400	.22	308	21	15	4	19
1600	.22	352	22	16	4	20
1800	.22	396	23	17	4	21
2000	.22	440	24	18	4	22

TABLE 41

OPERATIONS PER STAFF PER MONTH IN MAIN OPERATING ROOMS  
(Past Performance)

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	9.5	17.7	14.2	9.8	
Feb	9.6	12.2	12.5	15.0	
Mar	8.6	12.3	14.6	15.4	
Apr	9.3	13.6	16.4	14.9	
May	9.1	13.4	13.8	12.3	
Jun	9.9	12.2	12.8	11.4	
Jul	11.2	17.4	15.4	17.5	9.6
Aug	11.7	16.3	9.1	15.7	14.5
Sep	10.6	11.7	9.0	19.7	17.2
Oct	10.4	11.5	11.8	21.4	21.9
Nov	10.2	13.7	12.8	20.1	19.9
Dec		10.6		14.3	16.3
<u>1947</u>					
Jan			10.1	23.5	18.3
Feb			10.5	25.8	18.5
Mar				20.6	23.2
Apr					24.2
<u>Average</u>	10.0	13.7	12.5	18.1	18.4

Patient Load

3000 -	9.	17.7	14.1	15.1	
2000 - 3000		12.7	12.2	12.3	
1500 - 2000		16.8	9.0	17.1	
1000 - 1500	9.2	11.9	10.5	20.9	
700 - 1000	9.5		10.2		
400 - 700	10.4				18.4



TABLE 42

## OPERATIONS PER PATIENTS PER MONTH IN MAIN OPERATING ROOMS

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	0.14	0.20			
Feb	0.13	0.18			
Mar	0.13	0.20	0.15		
Apr	0.14	0.22	0.15	0.17	
May	0.15	0.23	0.15	0.22	
Jun	0.16	0.25	0.17	0.20	
Jul	0.18	0.25	0.17	0.22	0.21
Aug	0.17	0.26	0.15	0.21	0.26
Sep	0.15	0.22	0.15	0.20	0.23
Oct	0.16	0.25	0.21	0.22	0.25
Nov	0.18	0.23	0.19	0.18	0.24
Dec		0.23		0.17	0.19
<u>1947</u>					
Jan			0.15	0.18	0.23
Feb			0.16	0.22	0.23
Mar				0.21	0.29
Apr					0.29
<u>Average</u>	0.16	0.23	0.16	0.20	0.24

## DENTAL SERVICE

Dental services are staffed and equipped to provide modern dental care for both patient and staff personnel. The facilities include oral surgery, prosthetic and operative dentistry, X-ray and oral prophylaxis. Either a dental ward or specific beds are available for dental bed patients. An ocular replacement clinic is operated by the dental service in Philadelphia and San Diego.

### ORGANIZATION

The basic organizational pattern of the dental service is practically the same in all the hospitals. Each service is under the immediate supervision of a senior dental officer known as chief of the dental service. The small number of personnel involved and the professional nature of activities materially reduce internal organizational problems.

Work performed can be separated into professional and administrative categories. Dental officers responsible for particular professional functions, such as operative dentistry, usually report directly to the chief of service. Administrative operations, including the information desk, personnel statistical reports, requisitions for dental supplies and equipment, and correspondence files and records, are supervised by a senior dental technician who reports directly to the chief of service. Although the basic organizational pattern is fairly well standardized, the internal organizational structure varies in each dental service, especially with respect to organizational designations and professional nomenclature. In order to provide more uniformity and clarify the internal structure, the Dental Division in the Bureau of Medicine and Surgery should develop a standard organization chart to be used as a pattern for organizing hospital dental services. It is realized that the organization will necessarily vary in the smaller hospitals where some of the sections may be consolidated or eliminated.

### METHODS AND PROCEDURES

Use of Standard Form NAVMED-HF-57, Request for Special Examination and Treatment, in Referring Patients for Treatment: Patients reporting to the hospital with a strictly dental diagnosis should be examined by a dental officer and admitted to the dental ward when hospitalization is indicated. All other hospital patients should be referred to the dental service on standard form NAVMED-HF-57, Request for Examination and Treatment. This form will contain



patient's name, rate ward, medical diagnosis and a request for the desired information or treatment. A report of the examination made and treatment rendered should be entered on the "HF-57", which becomes a permanent part of the patient's hospital record. If this form is properly utilized, no other special forms are necessary in referring patients for dental treatment.

Use of Local Forms or Cards to Record Examinations and Treatment: Various local forms or cards have been established by hospital dental services to obtain a record of examination and treatment for each individual patient. The following procedure, which is essentially the same as that used in one of the largest hospitals, eliminates the necessity for individual examination and treatment cards, and assures the adequate maintenance of records on patients examined and treated.

1. Ward sends patient to dental service with Special Examination and Treatment Request, NAVMED-HF-57.
2. Clerk at reception desk sends patient to examination room.
3. Dental officer (usually chief of service) examines patient and makes appropriate entries on "HF-57".
4. Corpsman, in examination room, makes proper entries, including patient's name, date and treatment prescribed in log (the standard dental treatment book can be used for this purpose).
5. Patient with "HF-57" is then escorted or sent to the dental officer specified by examining officer.
6. Dental officer enters date of appointment in dental treatment book and also on "HF-57".
7. On date of appointment ward sends patient to dental service for treatment with original "HF-57". Treatment rendered is entered in dental treatment book and on "HF-57", which is returned to ward with patient.

Recording of Dental Treatments in the NAVMED-H-4: Every hospital is encountering difficulty in ascertaining that dental work for patient is recorded on the Dental Record, NAVMED-H-4. There is no particular problem with staff personnel, since they bring their records with them when reporting for treatment. Health records of hospitalized personnel are usually on file in the patient record office; however, a large number are often in various wards for

referral purposes.

In order to insure that all dental treatments are entered in the health record, it is recommended that hospitals institute the following procedures:

1. Dental service clerk prepares a list of patients treated each day.
2. Forwards list of patients treated to records office, and obtains health records.
3. Completes proper entries on the "H-4", and returns records to the records office the following day along with the new list of records to be drawn.
4. When the "H-4's" are removed from the record for any reason, a slip is inserted stating that the H-4 has been removed by the dental service. In this way the patient will not be discharged with the "H-4" detached from his health record.
5. A hospital "standing order" should be issued specifying that if the health record is on the ward, it shall accompany the patient when he reports for dental treatment.

Examination and Consultation Period: Not all hospitals have established specific hours for examinations and consultations. Both patients and staff may visit the dental service at any time during the day. This practice wastes both the time of dental officers by excessive interruptions in the daily schedule, and of staff personnel by increasing time "off-the-jobs". It also affects patient service and patient morale by creating extensive waiting periods prior to receiving treatment. It is recommended that each hospital establish specific hours for examinations and consultations in order to eliminate these conditions.

Maintenance of Duplicate Records on Dental Supplies and Equipment in the Dental Service and Finance Division: Hospital dental services are maintaining complete records on dental supplies and equipment. At the same time the finance division is charged with responsibility for establishing and maintaining records on all hospital supplies and equipment.

Bureau of Medicine and Surgery Circular Letter No. 47-19, of 20 February, specifies that the dental service of a naval hospital is a constituent part of the hospital professional service and operates in all respects in the same manner as the surgical, medical, and other services operate and function.

It is significant that the other hospital services are not maintaining stock records as they rely on the finance division for the performance of this function.

Each hospital dental service requires information on supplies and equipment expended in



order to develop usage rates. However, the medical stores control system now being set up in all hospitals will establish usage rates for all supplies, including dental. This and other data required by the dental officer in making decisions on dental needs are always available in the main stock records. As a matter of fact, dental personnel check the main records periodically to correct their accounts.

Action should be initiated to eliminate the maintenance of duplicate dental supply and equipment records in naval hospitals.

Reports and Forms: The number of dental reports is not voluminous. Practically all of them are required by the Bureau for the purpose of obtaining specific information concerning dental activities in each hospital. Before final recommendations can be developed concerning the simplification or elimination of required reports, it will be necessary to analyze how the information submitted by the hospitals is used by the Bureau.

The following comments are therefore made with the full realization that they are based on the information obtained at the hospital level only.

Appointment Cards: Each hospital using a dental appointment card has devised a local card to conform with the desires of the individual hospital dental service. It is noteworthy that a standard card has not been developed and that, therefore, there is no uniformity in cards employed at various hospitals. If the procedure recommended above under "use of NAVMED-HF-57", is employed, the "HF-57" should suffice as the appointment card for patients. The use of an appointment card for staff personnel is also of questionable value as it is often lost or discarded. One of the largest hospitals did not use an appointment card, since experience had indicated that it served no useful purpose. It is recommended that the use of the dental appointment card be discontinued.

Monthly Prosthodontia Report: The Monthly Prosthodontia Report, NAVMED-610 is primarily a recapitulation of the individual Reports of Prosthetic Dental Treatment, NAVMED-L, prepared for each patient receiving prosthetic treatment. One of the main objectives of the prosthodontia report is to obtain detailed data on the amount of gold and other precious metals used. This tight control was undoubtedly necessary during the war when the dental organization was greatly expanded, and a detailed reporting system was required to insure that precious metals were not being misused. However, the necessity for the continuance of such a rigid control in peacetime operations is questionable.



A NAVMED-L, Report of Prosthetic Dental Treatment, is submitted for each individual patient. The Bureau should be able to obtain adequate information on the amount of precious metal expended from a compilation of data submitted on the NAVMED-L's.

Other pertinent information on NAVMED-610 is also supplied by NAVMED-K, Report of Dental Operations and Treatment.

In view of its duplication of other reports, serious consideration should be given to the discontinuance of NAVMED-610.

The Semi-Annual Dental Report, NAVMED-461: During peacetime the information on equipment and facilities supplied by items 3 to 14 inclusive on NAVMED-461 should, if necessary, be brought to the Bureau's attention by the district dental officers. In addition, most of the same information is included in the Annual Dental Report. The personnel data requested on NAVMED-461 can be included on the Semi-Annual Dental Officer Personnel Report, NAVMED-785. It is therefore recommended that the Semi-Annual Dental Report, NAVMED-461, be discontinued.

Semi-Annual Dental Officer Personnel Report, NAVMED-785: Some of the personnel data requested on NAVMED-785 duplicates information supplied on NAVMED-461. Statistics on dental officers are the same on both forms. As stated above, the Semi-Annual Dental Report, NAVMED-461, should be discontinued and all necessary personnel data should be furnished on NAVMED-785. There is more than sufficient space on this form since the present roster column can be reduced to cover only the space actually required. If the two reports are consolidated, the title should be changed from Dental Officer Personnel Report to "Dental Personnel Report".

#### WORK MEASUREMENT AND STAFF REQUIREMENTS (excluding dental officers)

Past Performance: Tables 85 through 89 in Appendix II show performance at the hospitals studied in terms of visits per hospital patient per month and visits handled by the dental staff. Table 44 is a summary of the five hospitals.

The workload expectancy, i.e., the number of sittings per patient per month, is fairly consistent, with the exception of Great Lakes. The reason that Great Lakes varies so much from the other hospitals is not known.

The number of sittings per month handled per enlisted staff varies considerably, ranging from about 50 at Portsmouth to 200 at San Diego. Further, performance in terms of visits per enlisted staff was, with the exception of San Diego, much lower in the past few months than the early part of 1946 at these same hospitals.



Proposed Standard Enlisted Staff Requirements: One sitting per patient per month is an expectancy of dental activity which should be reliable to within 20 percent. Statistics show that 200 sittings per worker per month is a reasonable standard for performance at patient loads of 800 or more, varying down to 100 at the smaller hospitals.

The proposed standard enlisted staff requirements in Table 43 have been developed on this basis.

#### RECOMMENDATIONS

1. A standard organization chart should be developed for use as a pattern for organizing dental services.
2. NAVMED-HF-57 should be used in referring patients for dental treatment.
3. The procedure recommended in the text should be accepted to eliminate local forms and cards used to record examinations and treatment.
4. The procedure recommended in the text should be established to insure that dental treatments are recorded in the Dental Record.
5. A specific dental consultation and examination period should be established.
6. The use of dental appointment cards is not essential.
7. Maintenance of duplicate records on dental supplies and equipment should be discontinued.
8. Elimination of the Monthly Prosthodontia Report, NAVMED-610, should be considered.
9. The Semi-Annual Dental Report, NAVMED-461 should be discontinued.
10. The Semi-Annual Dental Officer Personnel Report, NAVMED-785, should be revised.
11. The proposed standard staff requirements on Table 43 should be adopted.

TABLE 43

## PROPOSED STANDARD STAFF REQUIREMENTS FOR DENTAL SERVICE

<u>Patient Load</u>	<u>Sittings per Patient per Month</u>	<u>Total Sittings Per Month</u>	<u>Sittings per Enlisted Staff</u>	<u>Enlisted Staff Required</u>
200	1.0	200	100	2
400	1.0	400	150	3
600	1.0	600	200	4
800	1.0	800	200	5
1000	1.0	1000	200	6
1200	1.0	1200	200	7
1400	1.0	1400	200	8
1600	1.0	1600	200	9
1800	1.0	1800	200	10
2000	1.0	2000	200	11



TABLE 44  
DENTAL SERVICES - PAST PERFORMANCE

<u>Date</u>	<u>Portsmouth</u> (Approximate)		<u>Philadelphia</u>		<u>Great Lakes</u>		<u>San Diego</u>		<u>Newport</u>	
	Sittings		Sittings		Sittings		Sittings		Sittings	
	Per Enl. Staff	Per Patient	Per Enl. Staff	Per Patient	Per Enl. Staff	Per Patient	Per Enl. Staff	Per Patient	Per Enl. Staff	Per Patient
<u>1946</u>										
Jan	95	2.16	202	0.66	158	0.41	196	1.01	105	0.79
Feb	98	1.47	100	0.62	124	0.66	167	0.85	95	0.68
Mar	123	1.49	84	0.58	117	0.46	199	0.97	110	0.83
Apr	80	1.02	108	0.79	154	0.40	154	1.12	107	0.97
May	62	0.79	95	0.88	83	0.27	170	1.42	111	1.05
June	157	0.72	116	0.86	76	0.32	126	1.11	126	1.00
July	51	0.53	128	0.90	100	0.29	175	1.29	164	1.36
Aug	40	0.57	94	0.90	63	0.51	153	1.10	183	1.31
Sept	57	0.68	79	0.81	51	0.51	179	1.25	134	1.10
Oct	52	0.69	85	0.93	50	0.44	220	1.42	142	1.17
Nov	52	0.69	78	0.83	53	0.60	193	1.36	65	0.58
Dec			91	1.04	70	0.62	184	1.36	109	1.08
<u>1947</u>										
Jan					91	0.48	182	1.42	99	0.91
Feb					74		196	1.24	93	0.74
Mar							204	1.20	77	0.85
Apr									109	1.15
May									50	0.57
Average		0.98		0.82		0.46		1.21		0.95

## EENT SERVICE

### ORGANIZATION

The EENT service consists of two main activities, the ward and the clinics. The clinics are usually divided into an eye clinic and an ENT clinic. At Philadelphia, additional functions are added, such as an aural rehabilitation clinic and adjunct prosthetic services.

The chief of the EENT service in all but one hospital reports directly to the executive officer, in the remaining hospital he is administratively responsible to the chief of the surgical service.

### PERSONNEL

Chiefs of the EENT services emphasized the lack of trained personnel, both in numbers and in quality. They pointed out repeatedly that as soon as a man approached the point of being considered adequately trained, he was transferred or discharged.

A nurse is assigned to the EENT clinic at some of the hospitals, but too much of her time is spent at the reception desk, away from the operating room and clinic.

### PROCEDURES

It is necessary for the EENT service to report the volume of work performed monthly to the finance officer so that out-patient and in-patient costs may be properly allocated. Log books are maintained to supply this information and for permanent record purposes.

No instructions from the Bureau concerning the method of arriving at production records are available and, as a result, the EENT services are not consistent in their reporting procedure. For example, the accounting procedure requires reports on the number of "examinations" and number of "treatments". No two hospitals agree on the difference between an examination and a treatment. One hospital calls the first visit an examination and each successive visit a treatment. Another hospital follows the same method but starts all over again if the patient's visits continue into the following month. A third hospital counts the first visit twice, both as an examination and treatment, and each successive visit a treatment. A fourth hospital ignores the distinction altogether. A fifth hospital issues no report. Another variable is that some hospitals include spectacle dispensing and some do not. The distinction between examination and treatments should be dropped, and reports should be made in terms of "visits". Over a period of a month, the time spent on different



types of examinations and treatments will average out to give accurate cost allocations.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS (excluding medical officers)

Four hospitals supplied statistics showing the total eye and ENT examinations and treatments (corrected insofar as possible for variations in method of counting), and the enlisted staff assigned to the EENT service for the past year to two years, (Tables 90-93 in Appendix II).

The total number of visits per patient per month shows remarkable consistency despite the fact that many of the visits are out-patient visits (Table 46). Variations from the average rarely exceed 20 percent. An expectancy of 1.2 visits per patient per month is used in the computation of staff requirements, but it is probable that 1.2 visits is high.

The number of visits handled per staff member per month is not consistent. However, sufficient information is available to establish a performance standard of from 200 to 225 visits per staff member per month, a standard reached in more than 35 percent of the total months for which data were obtained.

#### STAFF REQUIREMENTS

Table 45 shows the proposed staff requirements for the EENT service, excluding wards.

#### RECOMMENDATIONS

1. Special qualification ratings should be established for EENT technicians.
2. The tour of duty of EENT technicians should be extended.
3. A civilian receptionist clerk should be employed in EENT clinics having a workload of over 500 visits per month, thus freeing the nurse for full-time clinical duty.
4. The method of reporting examinations and treatments should be clarified. The distinction between examinations and treatments should be discontinued and reports should be prepared in terms of "visits".
5. The proposed standard staff requirements in Table 45 should be adopted.

TABLE 45

## PROPOSED STANDARD STAFF REQUIREMENTS FOR EENT SERVICE

<u>Patient Load</u>	<u>Estimated Visits per Patient</u>	<u>Total Visits</u>	<u>Visits per Staff</u>	<u>Staff Required*</u>
200	1.2	240	100	3
400	1.2	480	150	4
600	1.2	720	200	4
800	1.2	960	200	5
1000	1.2	1200	200	6
1200	1.2	1440	225	7
1400	1.2	1680	225	8
1600	1.2	1920	225	9
1800	1.2	2160	225	10
2000	1.2	2400	225	11

\* Staff required includes the staff for the Eye Clinic, ENT Clinic, and operating rooms, but does not include ward corpsmen assigned to EENT wards, or medical officers.



TABLE 46

E.E.N.T. SERVICES  
VISITS PER PATIENT - VISITS PER STAFF

<u>Date</u>	<u>Portsmouth</u>		<u>Philadelphia</u>		<u>San Diego</u>		<u>Newport</u>	
	<u>Visits per Pa- tient</u>	<u>Visits per Enl. Staff</u>	<u>Visits per Pa- tient</u>	<u>Visits per Enl. Staff</u>	<u>Visits per Pa- tient</u>	<u>Visits per Enl. Staff</u>	<u>Visits per Pa- tient</u>	<u>Visits per Enl. Staff</u>
<u>1946</u>								
Jan	0.92	140	0.99	140	0.69		1.6	280
Feb	1.09	190	1.08	142	0.48		1.8	360
Mar	0.76	120	0.99	125	0.70		1.5	270
Apr	1.02	130	1.09	132	0.70		2.8	300
May	1.30	170	1.25	137	0.77	260	2.9	350
June	0.89	160	0.98	99	0.64	250	2.5	320
July	0.86	120	1.10	93	0.60	350	1.9	230
Aug	1.07	130	1.40	102	0.88		1.4	190
Sept	0.82	100	1.06	136	0.91		0.7	140
Oct	0.98	100	1.28	158	1.04	270	1.2	180
Nov	1.00	90	1.06	138	1.12	200	1.9	210
Dec			1.21	155	0.89	200	1.2	150
<u>1947</u>								
Jan					1.00	180	1.2	220
Feb					0.95	190	1.1	230
Mar					1.32	330	1.0	200
Apr					1.42	320	1.1	240
Average since 1 July 1946	0.91		1.18		1.01 (Since 1 July)		1.27 (Since 1 July)	

## X-RAY SERVICE

### ORGANIZATION

The X-ray service includes radiography, fluoroscopy, and X-ray therapy, and, in most hospitals, photofluoroscopy units. Except for one hospital, the chief of the X-ray service reports administratively and technically to the executive officer. In that hospital, he reports administratively to the chief of the surgical service.

The internal organization of the X-ray service depends mainly on local conditions, and should be left to the discretion of the local command.

### PERSONNEL

There is a definite shortage of trained X-ray technicians. Further, constant turnover due to transfers and discharges causes a continuous training problem. Most chiefs of X-ray services desire at least one female civilian X-ray technician both for continuity, and in the absence of a qualified WAVE X-ray technician, to service dependents.

All chiefs of the X-ray service complain of the lack of competent clerical assistance. There is considerable work at the reception desk, and the corpsmen are not typing reports accurately. Competent typists should perform these duties.

### METHODS AND PROCEDURES

Special Examination and Treatment Request, NAVMED-HF-57: Two hospitals use special local forms in lieu of NAVMED-HF-57, while the other three do not. The majority of the X-ray officers feel that the "HF-57" would be adequate if the ward medical officers prepared the requests properly. Local forms are, in effect, reminders of what information should be obtained. It is doubtful that these additional local forms are justified.

Files and Logs: Logs are maintained at the reception desk containing brief information on each examination. The method of keeping these logs varies significantly. In addition, two sets of files are maintained; one is usually an alphabetical file of all patients examined, the other a pathological file of particular case histories. Considerable time is spent in the transfer of information from reports to these files. One of the simplest systems observed is at Great Lakes where the carbon copy of the original report on NAVMED-HF-57 is used in lieu of a file card.



Production Reports: The X-ray service has to report the monthly volume of work, broken down for in-patient and out-patient services, so that costs may be properly allocated by the finance office.

Most of the reports show the volume of radiographs, fluoroscopy, and X-ray therapy in terms of total number of examinations and treatments. It is very doubtful if the slightly greater reporting accuracy introduced by separating examinations from treatments warrants the effort. A very large probable error is introduced in prorating time spent by the staff between treatments and examinations, which is sufficient to nullify the value of separating these two items. Statistics have shown that the proportion of each type of examination and treatment will balance out, and that costs can be allocated just as accurately by pro-rating total examinations and treatments (one total) between outpatient and inpatient services.

Chest photofluoroscopic examinations had just been, or were about to be, introduced in the hospitals. These will increase the volume of examinations requiring a small expenditure of time. If these examinations are made routine for all in-patients, there may be a far greater proportion of in-patient to out-patient examinations than for other types of examinations. If the chest photofluoroscopic examinations are counted on the same basis as other examinations, they may cause in-patient services costs to be reflected inaccurately.

If experience shows that (1) the proportion of out-patient and in-patient photofluoroscopic examination differs considerably from other types of examinations, and (2) the volume of these examinations is high (50 percent of total), it is suggested that gross inaccuracies in cost allocation be avoided by applying some simple corrective factor. Photofluoroscopy could be considered equivalent to one-third of an examination.

X-ray services lack standard instructions on how to count examinations and treatments. Such instructions are necessary. It was the consensus of opinion that examinations and treatments should not be handled separately, and that experience might show that corrective steps will be necessary in accounting for routine photofluoroscopy.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS (excluding Medical Officers)

X-ray services report the total examinations in radiography, fluoroscopy, photofluoroscopy and X-ray therapy. Statistics indicate that variations in radiography are indicative of all functions, and, therefore, the X-ray examination is felt to be the most appropriate work-load indicator.

Statistics obtained show excellent consistency in the number of X-ray examinations per patient per month. The extremes are rarely more than 20 percent from the average (Table 48).

The figure of 1.3 X-ray examinations per patient, per month, was chosen as the basis for predicting staff requirements. This figure is somewhat higher than the average both to allow for a safety margin, and because the trend shows a slight rise in the proportion of X-rays taken.

However, the use of chest photofluoroscopy has reduced the number of chest X-ray examinations, and experience may prove 1.3 X-ray examinations per patient, per month too high.

Statistics show considerable inconsistency in the production per staff worker (Table 49). Newport's production per worker is three times that of Portsmouth or Great Lakes; San Diego is twice as high.

From the statistics obtained, a standard performance expectancy of 200 X-ray examinations per worker, per month has been established, although two X-ray officers feel that this is probably too low and should be closer to 300. It may very well be that the figure of 200 can be considerably increased.

Staff Requirements: Table 47 contains the proposed standard staffing requirements for the X-ray service, based on an expectancy of 1.3 X-ray examinations per patient, per month, and performance approaching 200 X-rays per worker, per month.

If these staffing requirements are effected, the following savings will result:

<u>Hospital</u>	<u>Excess Workers</u>	<u>Expected Saving</u>
Portsmouth	2	\$ 4,000
Philadelphia	3	6,000
Great Lakes	5	10,000
San Diego	1	2,000
Newport	<u>-1</u>	<u>- 2,000</u>
Total	10	\$20,000
Estimated saving for all hospitals -		\$75,000

#### RECOMMENDATIONS

1. A civilian stenographer whose duties would include receptionist work should be employed for X-ray services handling more than 600 X-ray examinations per month (about 500 patients).
2. One female civilian X-ray technician should be employed to assist in training, provide continuity, and to service dependents.
3. The Special Examination and Treatment Request, NAVMED-HF-57, should be used in lieu of



local forms.

4. Standard methods of maintaining records should be devised.
5. Instructions should be issued by the Bureau regarding the use of standard nomenclature, and a method of reporting production to provide uniform cost allocation. Examinations and treatments need not be handled separately. Experience will indicate whether photo-fluoroscopy will require special handling in reports.
6. Table 47, the proposed staffing requirements for the X-ray service at various patient loads, should be utilized. This table is based on an expectancy of 1.3 X-ray examinations per patient, per month, and a performance standard of 200 X-rays per worker, per month.

TABLE 47

## PROPOSED STANDARD STAFF REQUIREMENTS FOR X-RAY SERVICE

(Based on expectancy of number of X-ray examinations per patient and assuming the volume of fluoroscopy, photofluoroscopy, and X-ray therapy will vary proportionately)

<u>Patient Load</u>	<u>X-ray Exams per Patient per Month</u>	<u>Total X-ray Exams per Month</u>	<u>X-ray Exams per Staff</u>	<u>Staff Required*</u>
200	1.3	260	100	3
400	1.3	520	150	4
600	1.3	780	175	5
800	1.3	1040	200	6
1000	1.3	1300	200	7
1200	1.3	1560	200	8
1400	1.3	1820	200	9
1600	1.3	2080	200	10
1800	1.3	2340	200	11
2000	1.3	2600	200	12

\* Special Staff requirements would be established for special services, such as a veteran out-patient service, or dependents' service in excess of 3000 out-patient visits per month.



TABLE 48

X-RAY EXAMINATIONS PER PATIENT PER MONTH  
(Does not include fluroscopy or X-ray Therapy)

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego*</u> (Without Dependent Outpatients)	<u>Newport**</u>
<u>1946</u>					
Jan	1.12	.75	.88	.84	1.00
Feb	.88	.68	.76	.74	.83
Mar	1.09	.77	.86	.79	.99
Apr	1.13	.95	.91	.99	1.26
May	1.30	.98	.85	1.08	1.47
June	1.23	.88	.76	1.44	1.24
July	.98	1.02	.83	1.31	1.66
Aug	1.14	1.02	.89	1.43	1.64
Sept	1.03	.92	.87	1.42	1.66
Oct	1.10	1.31	.94	1.35	1.93
Nov	1.05	.96	1.02	1.23	1.70
Dec		1.22	.92	1.26	1.75
<u>1947</u>					
Jan		1.18	1.07	1.34	1.89
Feb			1.10	1.24	1.29
Mar				1.23	1.69
Apr					1.81
Average	1.10	.97	.91	1.08*	1.47

\* Out-patient dependents' service is abnormally high, and therefore excluded. However, it is estimated that with normal out-patient load, the 1.08 average would increase to 1.25

\*\* Chest photofluoroscopy has not yet been installed. It is expected that with such an installation, the Chest X-ray load will decrease and reduce the last few months high average to about 1.30

TABLE 49

STAFF (EXCLUDING MEDICAL OFFICERS), AND X-RAY EXAMINATIONS PER STAFF  
(Does not include Fluoroscopy or X-ray Therapy)

Date	Portsmouth		Philadelphia		Great Lakes		San Diego		Newport	
	Staff	X-rays per Staff	Staff	X-rays per Staff	Staff	X-rays per Staff	Staff	X-rays per Staff	Staff	X-rays per Staff
<u>1945</u>										
Sept	15	152	23	153						
Oct	10	170	19	153						
Nov	9	159	16	180						
Dec	8	116	16	151						
<u>1946</u>										
Jan	7	188	16	198	24	270	31	1141	6	201
Feb	7	150	22	117	20	231	24	140	6	154
Mar	7	167	21	167	25	170	19	170	8	133
Apr	6	190	19	209	25	159	16	221	7	159
May	4	304	25	139	14	234	20	164	7	154
June	3	363	23	124	23	106	15	220	6	131
July	4	212	22	136	14	163	7	397	7	143
Aug	6	117	21	126	21	90	14	208	6	152
Sept	6	101	18	131	19	74	13	210	6	167
Oct	6	98	20	155	17	70	14	191	7	167
Nov	6	79	21	122	13	92	17	128	7	136
Dec			17	144	11	86	12	194	5	176
<u>1947</u>										
Jan			17	158	11	92	14	182	4	259
Feb					11	88	14	156	4	204
Mar							12	188	5	215
Apr									5	238





## LABORATORY SERVICE

### ORGANIZATION

The laboratories operate under the immediate supervision of the laboratory officer. At four hospitals the laboratory officer reports directly to the executive officer; at the fifth he reports administratively to the chief of the medical service.

In larger laboratories the organization includes specific units, such as serology, clinical chemistry, blood chemistry, hematology, etc. With the reduction in workload, many of these units are combined, and laboratory workers, in most cases, are used interchangeably.

The internal organization of the laboratory will have to be determined locally on the basis of the volume of work.

At Portsmouth and Newport, epidemiology was performed in the hospital laboratory. Philadelphia and San Diego have independent epidemiology units. At Great Lakes, this work is done by the naval training station. Where epidemiology and hygiene functions are performed on the hospital compound, such work should be the responsibility of the laboratory officer and be performed under his direction in order to provide for effective utilization of personnel assigned these duties.

Branch Laboratories: At some hospitals, small "branch" laboratories have been set up for the dependents' service and other units. While branch laboratories facilitate patient service, the disadvantages are greater than the advantages. Laboratory officers feel that this policy has affected the quality of work. In addition, effective cost control is not maintained, and additional personnel are required.

Where conditions permit, the laboratory should be accessible to both out-patient and in-patient services to eliminate the maintenance of branch laboratories.

### PERSONNEL

The Use of Civilians as Laboratory Technicians: The major problem mentioned by laboratory officers pertains to the shortage of trained personnel. In four of five hospitals, sufficient personnel are available numerically, but are inadequately trained. As a result, the laboratory officers not only have to do work which should be accomplished by technicians but also have to devote too much of their time to training technicians. Laboratory officers believe that training will be a continuous problem.



Most laboratory officers strongly recommend that registered civilian laboratory technicians be employed as unit heads, to perform routine laboratory work, and also to train corpsmen.

At Portsmouth the laboratory officer recommended that two civilians be employed out of a total complement of six. At Philadelphia, a civilian complement of five was recommended. The consensus of opinion was that civilian workers should comprise about one-third of the total laboratory force where sufficient corpsmen are available to cover the night watches.

A thorough job analysis should be made of laboratory occupations before civilian billets are established, so that complete, clear-cut employment specifications and pay rates may be determined.

#### METHODS AND PROCEDURES

The basic form used in hospital laboratories is Laboratory Examination, NAVMED-HF-27, which is generally used as a report to the department requesting the examination. This form is satisfactory. A log of all laboratory examinations is maintained to furnish a permanent record for the laboratory. Each hospital maintains a log for this purpose, but no two hospitals use the same log.

Recording Examinations: Each laboratory prepares a monthly report showing the total number of laboratory examinations, broken down into individual classifications. The report is not only used for technical purposes, but also provides the finance officer with information on the relative time spent on out-patient and in-patient work.

The hospitals differ considerably in the method of counting laboratory examinations. In two hospitals, a complete blood count and urinalysis are counted as one examination each, a third hospital counts a urinalysis as four examinations and a complete blood count as four examinations. A fourth hospital counts a urinalysis as one examination but a complete blood count as four examinations. Three of the hospitals perform routine laboratory examinations, consisting of a blood count, a Kahn, and a urinalysis, on all in-patients. A standard method of counting examinations should be established for uniform accounting practice.

Requests for routine laboratory examinations should be made by the admission unit, and the results of the examinations sent direct to the appropriate ward. The submission of these requests by the central admission desk will eliminate the delays caused in the past by the forwarding of requests by the individual wards.

WORK MEASUREMENT AND STAFF REQUIREMENTS (excluding Medical Officers)

Tests Performed per Worker: Considerable information, showing the total number of laboratory examinations performed and the staff on board at the time, was obtained from laboratories in each hospital (Tables 99 - 103 in Appendix II).

Table 52 shows the number of tests performed per worker, per month over the past year at each of the hospitals. Performance was markedly inconsistent. For example, Portsmouth, Great Lakes, and Newport have a production record of over 800 tests per worker, per month, whereas Philadelphia averages 555 and San Diego 490.

From the statistics obtained and from discussions with laboratory officers, a standard of 800 laboratory tests per month is considered a satisfactory performance standard.

Tests per Patient: In order to relate laboratory staff required directly to patient load, statistics were compiled showing the number of tests per patient, per month (Table 51). There is a consistent relationship between patients and tests performed. (The error due to different methods of counting was corrected insofar as possible.) Portsmouth, Philadelphia and Newport, where routine testing is performed, average ten tests per patient, per month. San Diego averages only 4.7 tests but routine testing is not conducted and, because of insufficient laboratory personnel, considerable work is done by interns. The laboratory at San Diego is not affording as complete service as the other hospitals. The number of tests made at Great Lakes is somewhat lower than is indicated because of the different method of counting.

The application of performance standards would enable the Bureau not only to determine laboratory staff requirements, but would also indicate the kind of service being supplied.

Savings resulting from the Adoption of the Proposed Standards: On the basis of the most recent workload, the application of the proposed standards would accomplish the following savings (Table 50):

<u>Hospital</u>	<u>Excess Staff</u>	<u>Payroll Savings</u>
Portsmouth	0	\$ 0
Philadelphia	8	16,000
Great Lakes	2	4,000
San Diego *	- 6	- 12,000
Newport	0	0
	<u>4</u>	<u>\$ 8,000</u>

\* San Diego requires six more workers to provide sufficient laboratory service.



#### RECOMMENDATIONS

1. The internal organization of the laboratory service should be determined locally on the basis of the volume of work.
2. "Branch" laboratories which exist at some hospitals should be discontinued if physical layout is not prohibitive.
3. Epidemiology and hygiene functions should be the responsibility of the laboratory officer.
4. Approximately one-third of the laboratory staff should be civilian laboratory technicians. A thorough job analysis should be made of the laboratory occupations before the civilian positions are established so that complete employment specifications and pay rates can be determined.
5. A standard method of counting laboratory examinations, and a uniform system of maintaining laboratory logs should be established.
6. Requests for routine laboratory examinations on incoming patients should be made by the admission unit and the results of the examination sent direct to the appropriate ward.
7. The performance standards recommended in Table 50 should be adopted.

TABLE 50

## PROPOSED STANDARD STAFF REQUIREMENTS FOR LABORATORY SERVICE

<u>Patient Load</u>	<u>Laboratory Tests Per Patient Per Month</u>	<u>Total Laboratory Tests</u>	<u>Tests Per Staff Per Month</u>	<u>Staff Required *</u>
200	10	2000	500	5
400	10	4000	700	6
600	10	6000	800	8
800	10	8000	800	10
1000	10	10000	800	12
1200	10	12000	850	14
1400	10	14000	850	16
1600	10	16000	900	18
1800	10	18000	900	20
2000	10	20000	900	22

\* Does not include Medical Officers.



TABLE 51

LABORATORY TESTS PER PATIENT PER MONTH  
(Past Performance)

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	10.5	8.1	8.1	6.4	9.0
Feb	9.7	6.8	8.9	5.6	7.3
Mar	11.9	7.5	11.8	5.5	7.3
Apr	11.5	7.8	12.4	6.8	10.0
May	11.3	8.7	11.4	8.2	10.8
June	11.3	9.6	10.1	8.1	11.1
July	8.6	8.9	6.6	3.9	13.1
Aug	10.0	10.3	5.5	4.0	13.7
Sept	8.4	8.3	5.6	4.2	11.8
Oct	10.0	9.8	7.0	5.5	11.2
Nov	9.7	8.0	7.0	6.3	12.8
Dec		8.8	7.6	4.7	13.5
<u>1947</u>					
Jan			7.9	4.9	10.8
Feb			8.1	5.5	7.5
Mar				5.7	10.3
Apr					11.5
Average	10.3	8.8	8.4 **	5.7 *	10.7

\* The number of tests at San Diego is low because (1) some routine testing has been performed by internes, and (2) there is not much routine testing. It is possible that the laboratory service is not as complete as in other hospitals because of claimed shortages in trained personnel.

\*\* The volume of tests at the Great Lakes Hospital is lower than indicated because of the method of counting. Much routine testing is not performed.

TABLE 52  
LABORATORY TESTS PER STAFF, PER MONTH  
(Past Performance)

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1945</u>					
Jan		500			
Feb		480			
Mar		500			
Apr	620	470			
May	560	450			
June	690	440			
July	480	530			
Aug	440	460			
Sept	510	490			
Oct	510	610			
Nov	480	520			
Dec	400	420			
<u>1946</u>					
Jan	700	740	1220	510	720
Feb	955	580	1010	550	580
Mar	1280	530	1100	600	650
Apr	1380	520	2180	770	740
May	960	610	1330	550	1130
June	1110	550	1300	490	1170
July	825	460	1080	280	990
Aug	770	470	580	250	960
Sept	615	510	500	270	900
Oct	760	620	630	280	860
Nov	730	540	690	470	900
Dec		530	630	430	980
<u>1947</u>					
Jan			620	540	850
Feb			600	640	600
Mar				780	660
Apr					760
Average from Jan 1946	925	555	980	490	840





## PHARMACY SERVICE

The pharmacy is the most extensively used therapeutic facility in each hospital. Supplying stock drugs and preparing solutions or prescriptions are standard pharmacy functions.

### ORGANIZATION

A chief pharmacist's mate is immediately in charge of each pharmacy. He is responsible for ordering supplies from the main storeroom, preparing prescriptions, supervising employees, and preparing reports. At several hospitals the chief in charge reported directly to the finance officer or an officer in that division. In such cases, the pharmacy, in actual practice, is organizationally a sub-unit of the finance division. Since the principal function of the pharmacy consists of dispensing drugs and solutions or prescriptions to the professional services, it should be considered in the same category as the other therapeutic facilities. The present organization structure should be revised to include the pharmacy under the professional services group rather than as one of the administrative divisions (Exhibit 1).

Some commands operate a separate pharmacy for out-patients, which is established as a branch of the main pharmacy. In view of the reduced number of in-patients and the importance of effecting peacetime economies, it is difficult to justify the maintenance of two individual units. In those commands where the layout is not prohibitive, immediate consideration should be given to the establishment of a single pharmacy.

### METHODS AND PROCEDURES

Some hospitals have established specific time schedules for submitting requests for drugs to the pharmacy, but this practice is not standard. In one large hospital, wards present requests whenever they desire, causing excess counter service by pharmacy personnel and increasing the time lost by ward corpsmen. In order to promote more effective pharmacy operations, it is recommended that the procedure be established in all hospitals whereby orders from wards and elsewhere are delivered to the pharmacy at a specific period each day, preferably before 10:30 a.m. Pharmacy personnel will fill the orders as quickly as possible and call each activity when its order is ready for delivery. Emergency orders should be sent to the pharmacy at any time.

Maintenance of Records on Receipt and Issue of Drugs: The practice of maintaining logs and written records on the receipt and issue of standard pharmaceutical products, with the exception of narcotics, poisons, and alcohol, has been discontinued by most commands. Such logs should



be discontinued in all hospitals. These records require considerable man-hours and are not essential for effective operations. Information required for reporting purposes can be obtained by numbering copies of ward drug lists and prescriptions, and retaining them on file.

The standard practice of maintaining complete records on narcotics, poisons, and alcohol should be continued to effect complete accountability for such drugs and to comply with legal requirements.

Dispensing Counters: Dispensing counters are not always constructed so as to prevent the entrance of unauthorized personnel. It is impossible for unauthorized personnel to enter the pharmacy at only one hospital. Here a cage-type window counter is used and the main entrance is kept locked. Since it is very important that only pharmacy employees have access to drug supplies, this arrangement is considered most satisfactory. In those pharmacies where a large counter is located within the pharmacy room, unauthorized personnel have easy access to the drug shelves through a low unlocked entrance built into the counter. In order to eliminate this unsatisfactory condition, the window-type counter should be installed in all pharmacies.

Physical Layout: Personnel in practically every pharmacy emphasize the fact that the internal arrangement of the space set aside for the pharmacy was not conducive to good performance. For example, in three pharmacies it is necessary to walk around a shelf extending the length of the room in order to obtain an item from one of the rear shelves. This situation could possibly be corrected by placing the shelf perpendicular rather than parallel to the dispensing window. A layout study of each pharmacy should result in improved working conditions and increased production without excessive alteration costs. However, in some hospitals it may be more desirable to establish a new pharmacy rather than to improve existing facilities.

#### RECOMMENDATIONS

1. Branch pharmacies should be consolidated with the main pharmacy where permitted by the physical layout.
2. Orders for drugs and other pharmaceutical supplies should be delivered to the pharmacy only at a specific period to be designated by the hospital.
3. The maintenance of logs and written records for drugs received and issued, with the exception of narcotics, poisons and alcohol, should be eliminated.
4. The window-type dispensing counter should be installed in all hospitals to prevent entrance of unauthorized personnel.
5. The physical layout of all pharmacies should be studied with a view toward more effective utilization of space leading to improved working conditions and increased production.

## WARD ADMINISTRATION

### ORGANIZATION

Ward administration is the responsibility of the ward medical officer who is responsible to the chief of the particular service. In small services, such as urology or EENT, the ward medical officer may also be the chief of service. The ward medical officer directs the ward nurse, who in turn supervises the ward corpsmen.

This organization is good in theory. In practice, its success depends entirely on the individual medical officer or nurse. A ward operates well when the ward medical officer or the ward nurse is an effective administrator. In cases where neither person is interested in administration, the situation is affected accordingly. However, the line organization of ward medical officer, nurse, senior corpsman, and corpsmen appears practical, and no changes are recommended.

### PERSONNEL

Ward Medical Officer: A majority of the ward medical officers do not devote sufficient attention to internal ward operation. Many are either uninterested or feel that to do the work properly would take too much time from their professional duties.

In recognition of the situation, it seems most practical to place the burden of responsibility on the ward nurse.

Ward Nurse: The severe reduction in 1946, and the current turnover and shortages tend to make the present nurse situation abnormal. The current nurse shortage has magnified certain problems which should be corrected.

The ward nurse is primarily an administrator, yet many nurses seriously lack an understanding of many administrative procedures. For example, most nurses are not sufficiently familiar with records procedures or are not thorough in applying them. As a result, there is continual friction between the wards and the records office because of errors and delays. Many nurses are noticeably lax in their responsibilities for linen and equipment and often fail to follow-up on their instructions to corpsmen.

Proper training appears to be the best solution. All nurses reporting to a hospital for duty should be indoctrinated in local administrative procedures and policies. The executive officer and the personnel officer, in addition to the chief nurse, should participate actively in the training of nurses. Basic classroom instruction is essential but



not enough. Follow-up conferences should be held regularly for all nurses with key administrative personnel.

Leadership training should be stressed. A course in supervisory training is most essential, since ward nurses are responsible not only for supervising but also for training corpsmen assigned to their respective wards. It would probably be better, at least in the initial stages of such a program, for the Bureau to select especially qualified nurses and Hospital Corps officers to conduct this training. Later, as most qualified personnel become available, selection of instructors can be made by the local command.

Ward Corpsmen: A general complaint from all key hospital personnel is that ward corpsmen are insufficiently trained. The classroom training of corpsmen is often curtailed or attendance is irregular due to the present shortage of corpsmen. Even more significant, the ward corpsmen are not receiving practical training on the wards. The ward medical officers and particularly the ward nurses are considered lax in teaching corpsmen nursing procedures.

The survey team is not in a position to verify or disprove these comments. However, it is believed that the Bureau should be aware of the criticisms.

Hours of Work: The hours of work for ward corpsmen vary somewhat between the hospitals. The port and starboard method is employed with alternate long and short days, and alternate week-ends off duty. Ward corpsmen work over 72 hours in the long week, and approximately 55 hours during the short week. This does not include special watches and other duties which may add four to ten hours per week.

Sometimes corpsmen are allowed time off on the long day, but most of this time is taken up by classroom training and other details. Newport uses ward corpsmen on outside details on their short day because of shortages in the grounds force.

Most medical officers believe that the corpsmen's hours are too long. Many instances were cited where corpsmen, particularly after special watches, were too tired to do their ward work effectively. The ward corpsmen are concerned more about the long hours than the difficulty of the work. Surprisingly, the strongest proponents of shorter hours on the wards are the old-time chiefs and Hospital Corps officers who had worked these long hours themselves. They feel that the efficiency of hospitals would be improved by a shorter work-week.

Studies made of many industrial operations during the war indicated that, over long periods of time, average maximum total production is obtained in approximately a 50-hour work-week. Beyond 50 hours, the fatigue element and, indirectly, morale so adversely affect

production as to overcome any production gained by additional hours of work.

The ward corpsmen are particularly cognizant of the inequity that exists between their working hours and those of other personnel in the clinical services and administrative divisions. (Ward corpsmen represent only about 35 percent of the total corpsmen on the hospital staff.) At present, like the ward corpsmen, the majority of corpsmen working in other units are not rated. Even if they were, ward corpsmen are not convinced that higher ratings necessarily should mean shorter working hours. They work with nurses, who, despite the shortage, work a basic eight-hour day. Further, ward corpsmen are products of a generation where the eight-hour day is an accepted standard and they do not adjust easily to the present long working hours. This was not true of the average ward corpsman before the war.

The long hours on ward duty discourages present ward corpsmen from making the Navy a career, particularly when they realize that promotions will not be as rapid in the next few years as in the past. Ward corpsmen make every effort to transfer from ward duty because of the long hours and the limited promotional opportunities.

In general, the corpsmen seem least anxious for ward work, yet that is the place of closest contact between patient and staff, and where personal service to the patient is of prime importance and under constant surveillance.

The commanding and executive officers are aware of the problem of long hours of work, but direct attention to the shortage of corpsmen which is most severe on the wards, and for that reason it would be impossible to shorten the work hours. Most commanding officers consider the hours on the wards too long, but they are hesitant to recommend anything as drastic as an eight-hour day.

Considerable statistical information was gathered on the distribution of corpsmen in considering the problem of availability of corpsmen for ward duty. Exhibit 22A shows that only 39 percent of the corpsmen are on wards, whereas an average of 34 percent are in the administrative services, and 27 percent on adjunctive clinical services other than wards. At Philadelphia, however, only 20 percent of the corpsmen are assigned to the administrative divisions.

Studies on work measurement, which are discussed at the beginning of this report, indicate that the average percentage of corpsmen on administrative duties can be reduced to 20 percent. This would mean that about one-third of the corpsmen currently engaged in administrative work (one-eighth of the total corpsmen at a hospital) would be available for ward duty.



The substitution of civilian workers for corpsmen, where possible, in such units as laboratory, physical medicine, and to perform the more menial tasks in the dependents' service should make more corpsmen available for ward duty. It might also be feasible to substitute civilians for corpsmen in extremely active wards where patients are not available for details. The duties of these civilians would be, primarily, cleaning and galley work.

The average active ward now employs five corpsmen; two port, two starboard, and one on night duty. A basic eight-hour day would require six corpsmen; two on A.M. duty from approximately 0600 to 1400; two on P.M. duty from approximately 1200 to 2100; one, the senior corpsman, from approximately 0800 to 1700; and one night corpsman from 2100 to 0600.

The approximate eight-hour day is feasible with adjustments in assignment and more efficient utilization of personnel. It is rapidly becoming a necessity in order to obtain better performance and improve morale.

Chief Pharmacist's Mates for Ward Duty: The heavy surplus of chief pharmacist's mates was apparent at all hospitals. It is difficult to find enough jobs which are traditionally suitable for chiefs, and many are performing duties far beneath their skills.

In some wards, particularly dermatology and syphilology (D & S), and venereal wards, chiefs are assigned successfully in lieu of nurses. Medical officers in hospitals where chiefs are used on all types of wards report satisfactory results. They believe that although all chiefs are not qualified for this type of work, many of them, with careful selection, would make adequate substitutes for nurses.

There are not enough nurses, generally, to supervise the ward corpsmen adequately. This is particularly true of those nurses on P.M. duty who have supervision of from two to six wards. Many corpsmen take advantage of this situation and are lax in the performance of their duties, particularly in the more routine cleaning tasks. The assignment of chiefs to supervise those wards, under the general supervision of the ward nurse, would help solve much of this problem.

Another possibility is to utilize chiefs as senior ward corpsmen directly under a ward nurse. One main objection is the hours of work. The use of chiefs only on a 0800 to 1700, or similar watch, should overcome this objection. A second major objection is the strained relationship which often exists between chiefs and nurses. Basically, this is caused by old-time chiefs who feel that they know as much about nursing as nurses, but that their promotional opportunities have been limited. There appears to be some justification for their argu-



ment, but it is hoped that opportunities for promotion to Hospital Corps officers will be increased by present legislation. Among the more recent chiefs, however, the resentment is not as noticeable. Many Hospital Corps officers claim these newer chiefs are not as qualified in nursing duties as first and second-class pharmacists' mates before World War II. Their services, however, should be utilized as fully as possible, since ward duty is of prime importance in the proper functioning of a hospital.

Ratings for Ward Corpsmen: The situation in regard to the rating of corpsmen was not normal at the time of the survey. There were comparatively few first, second or third-class pharmacist's mates in any of the divisions or services. This was particularly true of ward corpsmen where less than five percent were rated higher than first class hospital apprentice.

Traditionally, ward corpsmen ratings are low. The senior corpsman is the only pharmacist's mate, and he is usually a pharmacist's mate second-class. Because of this, the best corpsmen have migrated from the ward to the administrative divisions. There is considerable doubt that the work in the divisions is more difficult and responsible than work on the wards. The closest contact between patient and staff is on the ward, and the best qualified personnel seem to be needed there.

Ratings for corpsmen, as for any position, should be based on the skills and responsibilities involved. Thorough analyses of these ward positions would probably show them to be fully as difficult as most division jobs. The quality of work performed on the wards would undoubtedly be raised if promotional opportunities are increased for ward corpsmen. The corpsmen cannot be closely supervised all of the time, and, in effect, work on their own much of the time. This responsibility should be recognized by adequate rating.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

The chief determinant in estimating the number of ward corpsmen and ward nurses required is the number of wards in operation. Different types of wards have different staff requirements, but statistics show that the percentage of types of patients, e.g., surgical, medical, EENT, etc., are generally the same, and therefore the percentage of the different types of wards is roughly the same (Table 57). This survey revealed that the average number of patients per ward did not vary greatly among the hospitals studied, so the relationship of number of wards in operation to patient load is fairly consistent.

Ward Nurses: Wards are generally understaffed in the number of nurses per ward. These



shortages are most apparent on the night watch where one nurse often covers as many as six wards. The drain on nurses caused by demands of the dependents' service is responsible for most of the shortage. Then, too, a few nurses are performing administrative duties, such as linen room, nurse corps office, etc., which should be reassigned to corpsmen or civilians. Exhibit 22 shows that, on the average, 31 percent of the nurses are in the dependents service, 48 percent in the main wards, and 21 percent engaged in other tasks.

The average active ward requires two and one-half nurses: one A.M., one P.M., and the half-time services of a nurse at night. Table 54 however, indicates that four hospitals have from 0.9 to 1.4 nurses per ward, and that of the five hospitals, only Portsmouth is adequately staffed.

Some wards do not require the full complement of 2.5 nurses per ward. It is estimated that approximately 1.8 nurses per ward will provide adequate coverage in these wards. Line four of Table 56 shows the total number of nurses required for ward duty other than on dependents' wards. (Exhibit 21)

The nursing requirements for dependents' wards are discussed in the following section of this report.

Ward Corpsmen: The average active ward, at present, requires a complement of five corpsmen. Wards such as N.P. and heart wards usually require more. Others such as dental and certain EENT wards require less, depending largely on the number of ambulatory patients. As hospitals increase in size, the use of convalescent or so-called "sleeping" wards reduce ward corpsmen requirements per ward considerably.

The objections to convalescent wards are: (1) they frequently involve the transfer of a patient from the care of one medical officer to another, and (2) they make fewer patient details available to active wards. However, as some hospitals have demonstrated, it is possible in many cases to establish convalescent wards without impairing normal operations. A considerable saving in personnel has been effected where this has been accomplished.

In the calculation of the number of ward corpsmen required, it has been assumed that certain wards will require fewer corpsmen than the average active ward. It has been further assumed that the average ward will contain about 30 patients. The average complement for an active ward has been established at six corpsmen to provide for an eight-hour day.

Table 55 shows the proposed staffing for ward corpsmen at various patient loads.

Shortage of Ward Personnel: Almost all key hospital personnel complained of the shortages in personnel on the wards. Statistics compiled on nurses assigned to wards during the past 18 months verify these claimed shortages. In connection with corpsmen, the problem in some cases appears to be caused by the low output per corpsman rather than a shortage in gross numbers. It is difficult to determine the importance of the relationship of low output per corpsman, but it must be considerable. Statistically, however, comparisons of theoretical ward corpsmen requirements for an eight-hour day against past staffing indicate very real shortages in all hospitals

Table 54 for nurses, and Table 57 for ward corpsmen show considerable inconsistency in past performance in terms of staff per ward, and patients per staff. It is necessary that standards be adopted to provide for uniform staffing.

Table 53 for nurses and Table 55 for ward corpsmen are proposed to provide a sufficient staff to give a reasonable standard of service to the patient as indicated by the medical officers.

#### RECOMMENDATIONS

1. Nurses should be thoroughly indoctrinated in local ward procedures at the time of their assignment to the hospital. This indoctrination should be conducted by the personnel officer and the chief nurse.
2. A supervisory training program should be instituted for all nurses.
3. The Bureau should investigate claims of laxness in training corpsmen in nursing practices.
4. Hours of work for ward corpsmen should be reduced to a basic eight-hour day. This would result in an approximate 50-hour week as compared with the present work-week of well over 60 hours.
5. Where there is a surplus of chief pharmacist's mates, they should be detailed to ward duty in lieu of nurses, as supervisors for discipline and cleanliness on several wards, or as senior ward corpsmen; whichever assignment is best under local circumstances.
6. A job analysis should be made of the duties of ward corpsmen to determine appropriate ratings according to the difficulty and responsibility of the duties involved.
7. The proposed ward procedures (Appendix I) should be adopted as standard for all hospitals.



8. The ratio of patients to nurses for service patients (as distinguished from dependents) should be ten to one, and the ratio of patients to ward corpsmen six to one (Exhibit 21).
9. The staffing standards for ward nurses proposed in Table 53 should be adopted.
10. The staffing standards for ward corpsmen proposed in Table 55 should be adopted.

TABLE 53

## PROPOSED STANDARD STAFF REQUIREMENTS FOR NURSES

1. <u>Patient Load</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
2. Estimated No. of Wards	10	14	20	27	34	40	46	52
3. Ward Nurses per Ward	2.2	2.0	1.8	1.8	1.8	1.8	1.8	1.8
4. Ward Nurses (2. x 3.)	22	28	36	48	60	72	83	93
5. Other Nurses (e.g.Ch.Nurse, M.O.R., Dietitian, etc.)	5	6	7	8	9	10	11	12
6. Nurses (excluding dependents) (4. plus 5.)	<u>27</u>	<u>34</u>	<u>43</u>	<u>56</u>	<u>69</u>	<u>82</u>	<u>94</u>	<u>105</u>
7. Patients per Nurse ( $1. \div 6.$ ) (excluding dependents)	7	12	14	14	15	15	15	15
8. Nurses* (Dependents' Service)	8	12	16	20	24	27	30	32
9. <u>Total Nurses (6. plus 8.)</u>	<u>35</u>	<u>46</u>	<u>59</u>	<u>76</u>	<u>93</u>	<u>109</u>	<u>124</u>	<u>137</u>
10. Total Patients per Total Nurse ( $1. \div 9.$ )	6	9	10	11	11	11	11	12

## PROPOSED NURSE REQUIREMENTS FOR DEPENDENTS' IN-PATIENT SERVICE

11. Estimated Dependents Service	13	26	39	52	65	78	90	100
12. Patients per Nurse	1.6	2.2	2.5	2.7	2.8	2.9	3.0	3.1
13. Nurses Required ( $11. \div 12.$ )	<u>8</u>	<u>12</u>	<u>16</u>	<u>20</u>	<u>24</u>	<u>27</u>	<u>30</u>	<u>32</u>
14. H.C. and/or Civ. sub-prof. nursing (except maids)	5	10	15	19	23	27	30	32
15. Total Nursing Staff (13. + 14.)	<u>13</u>	<u>22</u>	<u>31</u>	<u>39</u>	<u>47</u>	<u>54</u>	<u>60</u>	<u>64</u>
16. Patients per Nursing Staff ( $11. \div 15.$ )	1.0	1.2	1.3	1.3	1.4	1.4	1.5	1.6



TABLE 54

## PAST PERFORMANCE OF NURSES IN FIVE HOSPITALS

## PATIENTS PER NURSE

<u>Date</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
<u>1946</u>					
Jan	4.8	8.4	12.0	12.0	15.2
Feb	5.9	7.5	9.2	12.5	13.8
Mar	6.1	8.0	8.8	11.9	11.4
Apr	6.4	8.5	8.8	11.1	9.8
May	7.2	8.8	9.1	9.5	8.5
Jun	7.7	8.1	9.0	8.6	9.2
Jul	7.9	10.9	9.2	11.9	12.0
Aug	10.5	12.3	11.9	27.6	18.6
Sep	14.3	20.3	17.4	24.2	19.6
Oct	12.4	18.0	15.7	22.5	17.8
Nov	10.2	17.9	14.2	20.5	18.1
Dec	11.5	16.9	13.1	17.8	16.3
<u>1947</u>					
Jan			12.9	19.7	21.1
Feb			13.6	18.9	22.0
Mar				19.4	20.6
Apr					15.5

## WARD NURSES PER WARD (EXCEPT DEPENDENTS)

<u>1946</u>					
Jan	3.7	5.2	3.4		2.8
Feb	3.5	5.1	3.4		2.2
Mar	3.1	4.9	2.9		2.6
Apr	3.0	4.2	2.8		2.5
May	2.4	3.6	2.4		2.4
Jun	2.5	3.5	2.4		1.9
Jul	2.7	3.1	2.7		1.4
Aug	2.4	1.9	2.0	0.6	0.9
Sep	2.1	1.4	1.0	0.6	1.0
Oct	2.3	1.4	1.0	0.8	1.1
Nov	2.4	1.3	1.2	0.8	1.2
Dec	2.2	1.4	1.2	1.1	1.2
<u>1947</u>					
Jan			1.2	1.0	0.7
Feb			1.2	1.1	0.8
Mar			1.1	0.9	0.9
Apr					1.0

TABLE 55

## PROPOSED STANDARD STAFF REQUIREMENTS FOR WARD CORPSMEN

<u>Patient Load</u>	(Assumed Standards)		<u>Number of Wards</u>	<u>Ward Corpsmen Required</u>
	<u>Patient per Ward Corpsmen</u>	<u>Ward Corpsmen per Ward</u>		
200	3½	6	10	60
400	5	5½	14	80
600	5-3/4	5-1/4	20	105
800	6	5	27	135
1000	6½	4-3/4	33	160
1200	6½	4½	40	185
1400	6-3/4	4½	47	210
1600	6-3/4	4½	53	235
1800	7	4½	60	260
2000	7	4½	67	285

TABLE 56

## PROPOSED TOTAL NURSING STAFF

<u>Patient Load</u>	<u>200</u>	<u>400</u>	<u>600</u>	<u>800</u>	<u>1000</u>	<u>1200</u>	<u>1400</u>	<u>1600</u>
Ward Corpsmen	60	80	105	135	160	185	210	235
Ward Nurses	<u>22</u>	<u>28</u>	<u>36</u>	<u>48</u>	<u>60</u>	<u>72</u>	<u>83</u>	<u>93</u>
Total Nursing Staff	82	108	141	183	220	257	293	328
Patients per Nursing Staff	2.4	3.7	4.3	4.4	4.5	4.7	4.8	4.9



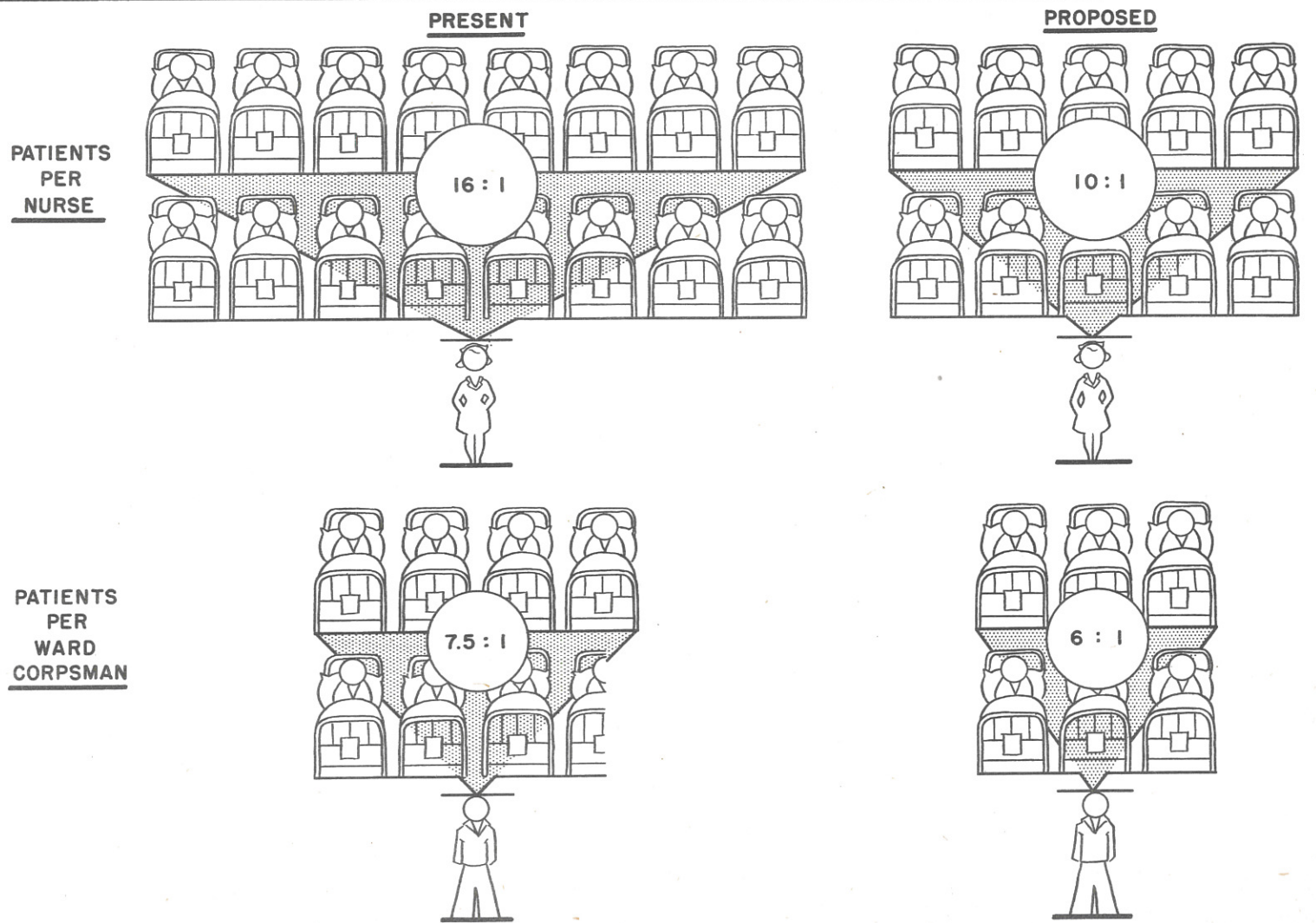
TABLE 57

## PAST PERFORMANCE OF WARD CORPSMEN IN FIVE HOSPITALS

Date	PATIENTS PER WARD CORPSMEN					WARD CORPSMEN PER WARD				
	Ports.	Phila.	Gr. Lakes	San Diego	Newport	Ports.	Phila.	Gr. Lakes	San Diego	Newport
<u>1946</u>										
Jan	7.4	9.2		3.7	7.4	4.8	6.8			6.0
Feb	8.5	6.8	9.2	3.7	8.3	4.9	8.3	7.1		5.0
Mar	7.9	6.8	7.4	4.2	8.3	4.7	8.0	7.4		4.9
Apr	7.2	7.3	6.6	4.3	7.5	5.2	7.1	7.2		4.7
May	6.0	8.0	7.9	4.9	7.1	7.0	6.0	5.6		4.1
Jun	9.1	6.5	9.9	4.2	8.4	4.4	6.7	4.7		3.2
Jul	11.2	5.2	9.8	4.4	8.0	4.3	8.6	5.1		3.6
Aug	6.6	4.6	9.6	4.6	7.7	9.4	8.9	5.4	10.9	3.5
Sep	6.8	4.4	6.4	5.4	9.2	9.5	9.1	6.6	9.1	3.3
Oct	6.3	5.0	5.9	9.6	8.8	9.4	7.7	6.6	5.3	3.6
Nov	5.6	5.2	4.6	9.8	8.4	9.1	7.2	8.2	4.8	3.7
Dec		5.3	8.3	8.8	7.5		6.6	4.9	5.2	4.8
<u>1947</u>										
Jan			7.2	9.8	5.3			5.2	4.8	4.9
Feb			9.0	10.1	7.1			4.2	4.6	4.4
Mar			8.8	10.7	7.8			4.0	4.2	3.9
Apr					8.3					3.8

# RATIO OF NURSING STAFF TO PATIENTS

EXHIBIT 21

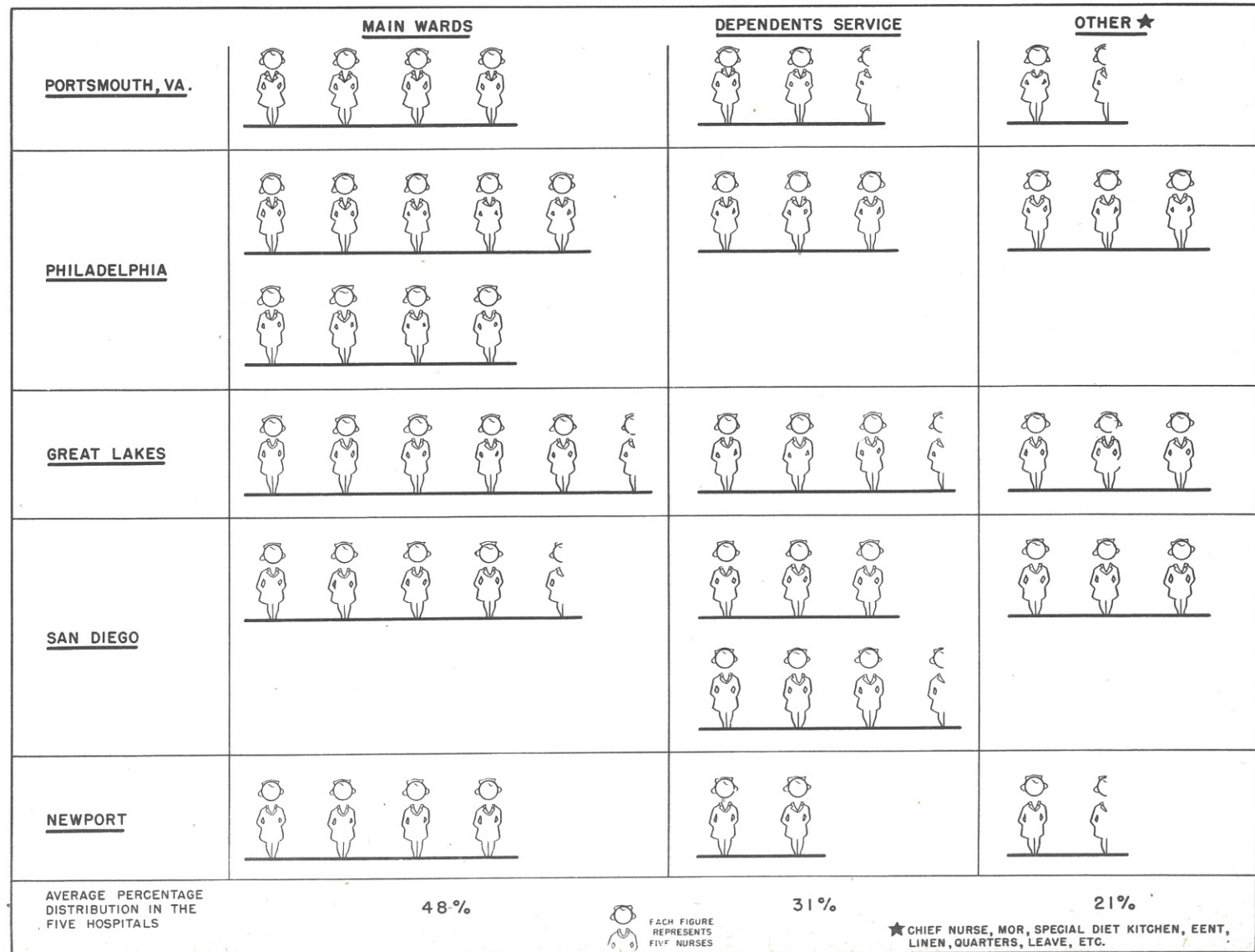






# DISTRIBUTION OF NURSES

EXHIBIT 22

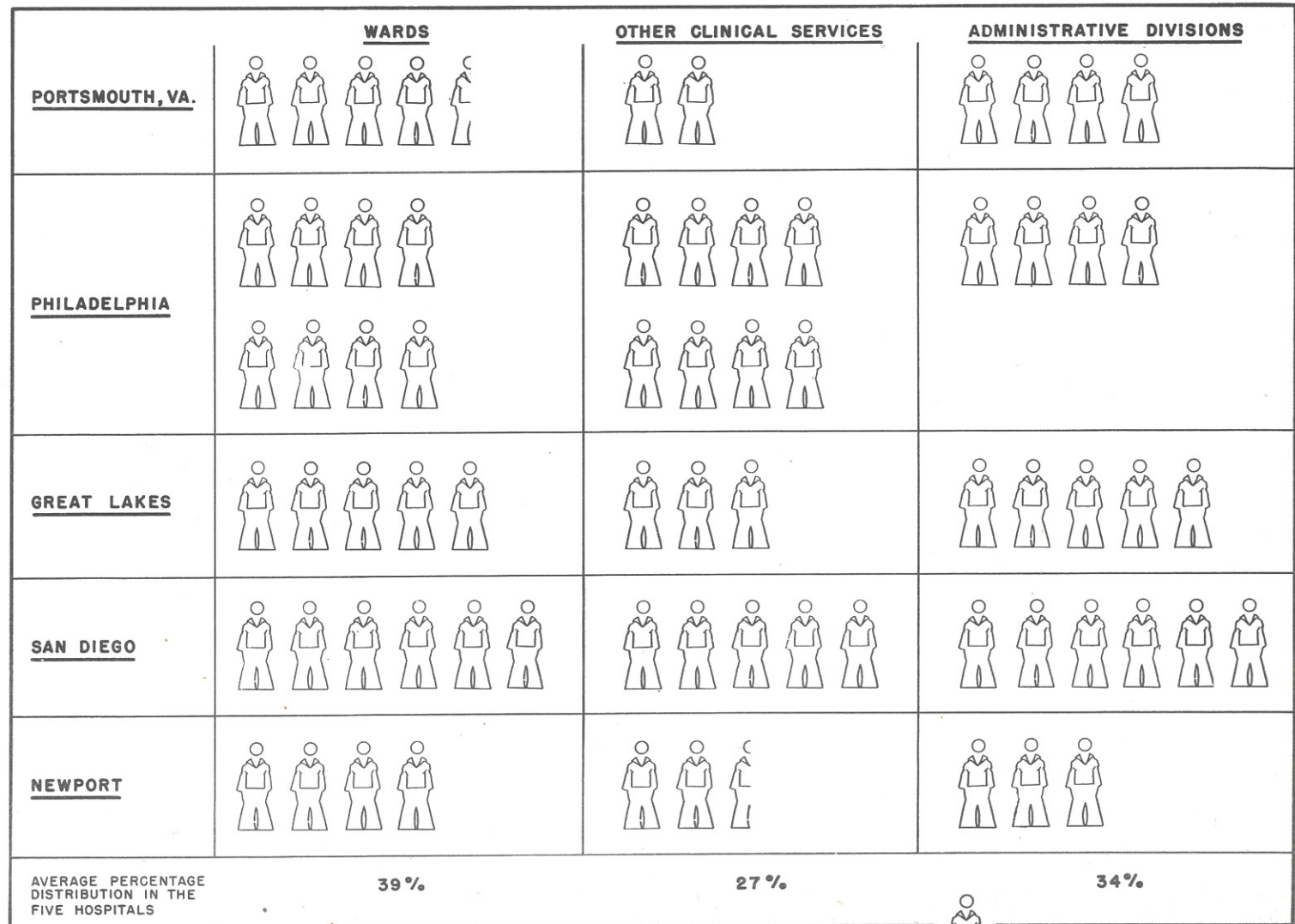






# DISTRIBUTION OF CORPSMEN

EXHIBIT 22A



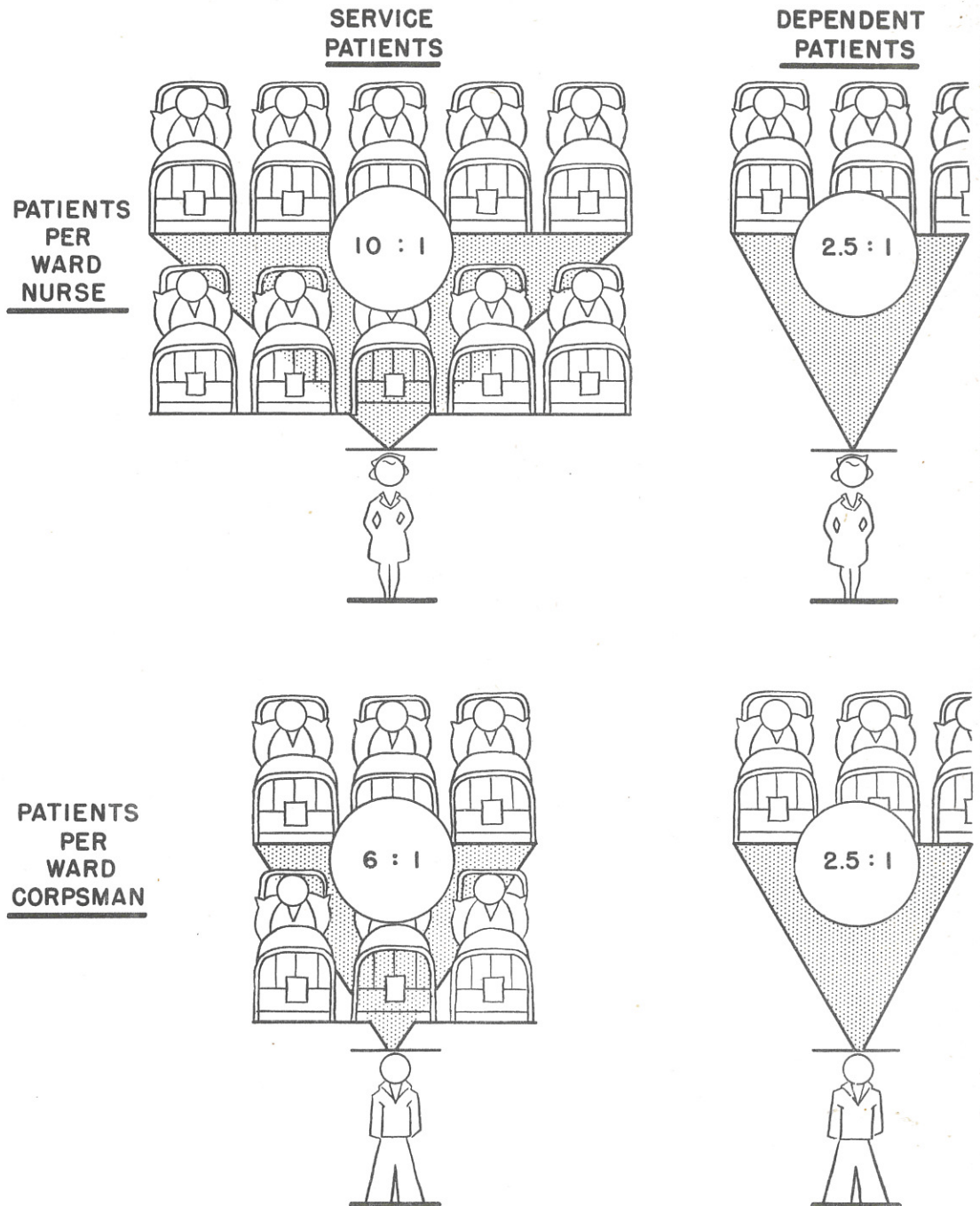
EACH FIGURE  
REPRESENTS  
20 CORPSMEN





# NURSING REQUIREMENTS

EXHIBIT 23



Drawn by MEDICAL STATISTICS DIVISION





## DEPENDENTS' SERVICE

There is a dependents' service equipped to care for both out-patients and in-patients at all of the hospitals. Facilities available for the care of dependents, however, vary considerably at each hospital. At one large hospital only two semi-permanent wards are maintained currently for female in-patients, while at a smaller hospital a large permanent modern building is utilized for these patients. The number and types of patients admitted and treatment rendered depend to a great extent on the characteristics of the medical officer in charge, and the attitude of the commanding officer toward dependents' care. In some hospitals practically all cases are accepted for hospitalization, while in others only the most acute cases are admitted with the exception of obstetrical patients who receive practically the same attention at all of the hospitals.

### ORGANIZATION

The chief of service is directly responsible to the executive officer, but operates independently with respect to daily operations. In some hospitals there is a trend toward the development of a small, independent dependents' hospital little related to the main hospital organization. The dependents' service is designated as the dependents' hospital at several naval hospitals. Any tendency to segregate the dependents' service from the hospital proper has a detrimental effect upon effective hospital operations, since all activities should be closely integrated if the best interests of both staff personnel and patients are to be attained. Insofar as possible, this service should function in the same manner as the other professional services in the hospital organization. Any adjunctive services, such as laboratory or X-ray, should be accomplished by the activities established for those duties (or their sub-units) rather than independent units established as part of the dependents' service. In some hospitals, doctors working in this service are responsible to the chief of service, while in others they are responsible to the medical or surgical service. In order to develop and maintain sound working relationships between the services, and establish uniform practices in the various hospitals, the Bureau should promulgate and require adherence to a standard policy on the assignment of medical officers to the dependents' service for both out-patient and in-patient work. It is suggested that officers assigned to dependents' work be technically responsible to their chiefs of service and administratively responsible to the chief of the dependents' service. This relationship should minimize any tendency of the services to become



separated from the main hospital organization. The organization structure of the dependents' service, with facilities for out-patients and in-patients, is essentially the same in each hospital. The internal organizational patterns are not standardized. However, in view of varying local conditions and to permit flexibility of operations, it is recommended that each hospital determine the most practical internal organization of the dependents' service.

#### PERSONNEL

Due to the type of patient and treatment required, the problem of the selection of personnel for dependent in-patients is more complex and difficult than for military in-patients. Practically all of the cases are women who require special care and attention. Most of the nursing has been performed by Hospital Corps WAVES and nurses. There has been a disproportionate decrease in WAVES due to demobilization; and although practically all WAVES assigned to hospitals have been placed in the dependents' services, a shortage prevails. Most of the WAVES working with dependents dislike the duty and state that they intend to transfer or obtain a discharge from the Navy. It is questionable, therefore, whether the establishment of a permanent WAVE corps will materially reduce the staffing problem in regard to dependents. It was observed many of the duties which the WAVES were performing, such as cleaning, serving patients and similar tasks, could be satisfactorily assigned to maids. It is recommended that hospitals emphasize the fuller utilization of maids in dependents' services in order to conserve personnel either in training or already trained for direct patient care.

Although more corpsmen are now being assigned to supplement the WAVES, there are many duties which can not or should not be performed by them in caring for female patients. However, corpsmen must be employed if action is not taken to obtain and train women to perform these duties. It is therefore recommended that civilian nurses' aides be recruited, and given sub-professional duties formerly assigned to WAVES. It is emphasized that maids should be assigned cleaning and galley details, and the practice of using trained personnel for these duties should be discontinued.

#### METHODS AND PROCEDURES

Neuro-psychiatric Out-patients: Hospitals do not have a clear understanding of their position in the treatment of neuro-psychiatric out-patients. These patients often require prolonged treatment and considerable individual attention on the part of staff medical officers. If it is determined that hospitals shall afford treatment for mental cases, the neuro-psychiatric



staffs should be increased accordingly; otherwise, such cases should not be accepted.

Appointments for Out-patients: One of the most common complaints of out-patients is the long periods they are required to wait before they can see a doctor. It is not unusual for a patient to sit in the waiting room for two or more hours. This situation generally results from the fact that most hospitals will not specify definite times for appointment. For example, a patient is told to come Tuesday morning rather than nine o'clock Tuesday morning. The out-patient clinic at Philadelphia is encountering less difficulty and avoiding some of the congestion observed in other hospitals by operating a sound appointment system. All non-emergency patients requesting treatment are given an appointment. The appointment schedule is so established that the medical staff can see the patient only at the designated hour. It should be emphasized that the system will collapse unless it is administered by a well-qualified person and strictly adhered to by both patients and staff.

If hospitals make a sincere attempt to systematize the treatment of out-patients, less difficulty will be encountered in processing the heavy out-patient load.

Diagnostic Nomenclature for Female Diseases: A complete modern diagnostic nomenclature system on female diseases should be established. The diagnostic nomenclature as prescribed by the Manual of the Medical Department is considered inadequate by the medical officers with whom this problem was discussed. Apparently it was not contemplated that hospitals would provide extensive care for women when the present nomenclature was established. A modern diagnostic system based on the American Medical Association's nomenclature for women's diseases would assist staff personnel in the effective performance of their duties and generally improve dependents' services.

Policy on Admission of Dependents: The Bureau should ascertain that the established policy on types of dependent cases to be admitted for in-patient care, particularly for females, is correctly interpreted and uniformly applied at all hospitals maintaining dependents' services.

The Manual of the Medical Department specifies that dependents shall be admitted only for acute medical and surgical conditions, exclusive of nervous, mental, or contagious diseases or those requiring prolonged care on account of chronic diseases. It appears that the clause "acute medical and surgical conditions" is subject to several interpretations, or that some hospitals are not complying fully with the established policy. In one hospital, for example, only about 50 percent of the patients were admitted for acute medical and surgical conditions, excluding maternity cases. Since female in-patients require considerable medical and nursing



care, the staff per patient ratio is considerably larger than for service patients. At present, due to the critical shortage of nurses and corpsmen, the treatment of dependent patients should be adjusted to the number of personnel available in order to maintain quality standards consistent with Bureau policy. Due to the rather extensive dependents' program at some hospitals, nursing care is being diverted that should be allocated to service personnel. It is noteworthy that 40 percent of the total nursing staff in one hospital is assigned to the dependents' service.

Unless a concerted attempt is made to regulate dependent patient care in some hospitals, other services will be adversely affected and at the same time the dependents' service will be criticized because of inability to properly care for patients admitted.

Duplication of Services: Some dependents' services maintain their own laboratory, pharmacy, X-ray service, etc., or a part of such facilities, for the purpose of providing better service to their patients. This results in excess personnel requirements and in some cases does not appear justified. The problem, almost invariably, was created because of the poor location of the particular service which is being duplicated. In some instances these services could be relocated, such an expense being easily justified by savings in personnel. Part of the problem is unsolvable because of the basic design of some hospitals.

Adjunctive services maintained by the dependents' service should be discouraged. In some cases, it may even mean bringing dependents' wards and out-patient departments closer to the service.

#### WORK MEASUREMENT AND STAFF REQUIREMENTS

Shortages in Personnel: Shortages in personnel are most severe in the work which is normally the duty of Hospital Corps WAVES. The nurse shortage became less acute toward the end of the survey, but is still considerable. However, the diversion of nurses to the dependents' service causes a shortage on other wards. Maid service is generally adequate quantitatively, although in some cases more maids should be used to replace military personnel on galley and ward cleaning details.

The survey team did not, in general, attempt to study the problems of the medical officers, but the shortage in the medical staff for dependents' service was apparent. Medical officers attached to the dependents' service are carrying an extremely heavy workload, especially at San Diego and Newport.

Statistics on Past Work Load: The statistics show that some generalizations can be made concerning the expected work load (Tables 114 thru 118 in Appendix II):

- a. The volume of out-patient visits is fairly proportionate to the number of military patients.
- b. The dependent in-patient load is fairly proportionate to the total patient load.

The only real exception is at San Diego where the ratio of out-patients to in-patients is much greater than would normally be expected. This situation is caused by the fact that there are so many more dependents in the area than active duty personnel.

Table 59 shows the expected dependent in-patient load for various overall patient loads. The in-patient load has been chosen as the work load indicator since most of the personnel in the dependents' service are concerned primarily with in-patients. Where out-patient visits are abnormally high, specific personnel requirements can be established, e.g., one person for every thousand out-patient visits per month in excess of 3,000. The chief purpose of relating dependent patient load to overall patient load is to afford a reasonable uniform basis for personnel planning.

Staff Requirements: Since the staffing problem is of such great concern to the dependents' services, the team spent considerable time in relating staff requirements to dependent in-patient load. The conclusions arrived at are based on discussions with dependents' service personnel, and the evaluation of past performance (Table 59) in terms of the minimum quality of service as indicated by the chiefs of service.

Table 58 shows the proposed standard staff requirements, which are probably accurate to within ten percent. The column headed "Hospital Corps and/or Sub-professional Civilians" refers to the level of work which has been performed by Hospital Corps WAVES. Some hospitals have begun to replace these WAVES by civilian sub-professional workers. It is expected that corpsmen or civilians can be substituted for approximately 20 percent of the nurses, although this would not be the most satisfactory arrangement.

#### RECOMMENDATIONS

1. The dependents' service should be considered an integral part of the hospital. Attempts to treat this service as an independent organization should be discouraged. Separate adjunctive services, such as a special pharmacy, laboratory, etc., should be avoided in the interests of economy.



2. In some hospitals the distribution of nurses between the dependents' service and the regular military wards is out of proportion. Nursing care which should be allocated to service personnel should not be diverted to dependents.
3. WAVES and corpsmen should be relieved of tasks which can be performed by civilian maids.
4. A definite policy should be established concerning the treatment of neuro-psychiatric out-patients.
5. An effective appointment system should be established and maintained for out-patients.
6. Out-patient services should be adequately staffed with medical officers assigned on a full or part time basis.
7. A complete modern diagnostic nomenclature system on female diseases should be established.
8. The established policy relative to types of dependent cases to be admitted for in-patient care should be uniformly interpreted and applied.
9. The proposed standard staff for the dependents' service, as shown on Table 58 should be adopted.

TABLE 58

PROPOSED STANDARD STAFF REQUIREMENTS FOR DEPENDENTS SERVICE  
(Outpatient and Inpatient)

<u>Inpatient Load</u>	<u>Staff Per Patient Ratio</u>	<u>*Total Staff Required</u>	<u>Medical Officers</u>	<u>Nurses</u>	<u>Hosp. Corps and/or S.P. Civilians</u>	<u>Maids</u>
20	1.4	28	5	10	8	5
40	1.2	48	7	16	16	8
60	1.1	66	9	23	23	11
80	1.00	80	12	28	27	13
100	0.95	95	15	32	32	16

\* Plus 1 per thousand outpatient visits per month, over 3,000 visits per month.

Expected Dependent Inpatient Load for Overall Patient Load  
(Plus or Minus 25%)

Overall Patient Load	200	400	600	800	1000	1200	1400	1600
Dependent Inpatients	13	26	39	52	65	78	90	100



TABLE 59

STAFF PER INPATIENT RATIO FOR DEPENDENTS SERVICES  
(Past Performance)

<u>Inpatient Load</u>	<u>Portsmouth</u>	<u>Philadelphia</u>	<u>Great Lakes</u>	<u>San Diego</u>	<u>Newport</u>
20-30	1.7				1.2
30-40	1.6	1.5			
50-60	1.7	1.0	1.2		
60-70		1.4	1.15	1.5	
70-80		0.8	0.9	1.3	
80-90			0.8	1.1	
90-100				1.0	
100+				1.05	

## REHABILITATION SERVICE

During the war an extensive rehabilitation program was developed by the Bureau and installed in naval hospitals. The program included those activities which supplement ordinary professional treatment to expedite recovery and return to duty, or promote maximum adjustment for return to civil life. A rehabilitation board and a rehabilitation service were the two principal organizational units established to implement the program. The Board consisted of a chief of rehabilitation service, clinical services (as appropriate), rehabilitation service activities, contributory activities (as appropriate), and special programs (for blind, deaf, amputees). Its principal functions were to consider all problems affecting the program, and to insure that all rehabilitation activities were operating effectively. The five main subdivisions of the rehabilitation service were educational services, physical therapy, occupational therapy, physical training, and civil readjustment.

Although the program, as established, is still included in the organization of naval hospitals, it is not functioning as originally devised to meet wartime conditions and needs, primarily because qualified staff personnel have been demobilized, and the necessity for a full-time program has decreased due to the return to peacetime operations and a change in the type of patient receiving treatment.

There is actually very little consistency in the rehabilitation program being operated at the different hospitals studied. In one instance, practically a full scale program is in operation, while in another it is confined almost entirely to work details and physical therapy.

The following discussion is concerned primarily with those activities which are officially designated to comprise the rehabilitation service, since they are the main organizational units and were established to perform the principal rehabilitation functions.

Physical Therapy: With the exception of one hospital, where a medical officer qualified in physical medicine is in charge of the rehabilitation service, patients are referred directly from the wards to physical therapy for treatment. Practically all contacts are with individual ward medical officers. The physical therapy activity functions on rather an independent basis with very little, if any, supervision from the chief of the rehabilitation service. Daily operations are such that very little technical control is actually necessary, other than that exercised by the technician immediately in charge. Since the work performed by physical therapy is so closely aligned with ordinary professional care, it is believed that the



activity should be attached to a specific professional service. The functions performed by the orthopedic service are most closely related to physical therapy, and, therefore, the officer-in-charge of orthopedics would be the most logical person to direct the activities of physical therapy. However, if a physical medicine service is established, physical therapy would be a component part of that service.

A WAVE officer is usually in charge of physical therapy. When these officers are no longer available, they should be replaced by civil technicians. Due to the critical nursing shortage, nurses should not be assigned as supervisors in physical therapy.

A local form is generally used by ward doctors in requesting physical therapy treatment. One of the larger hospitals intends to use NAVMED-HF-57, Request for Special Examination and Treatment, as soon as the supply of local forms is exhausted. Personnel in physical therapy agree that the NAVMED-HF-57 form is adequate and should be used in lieu of the present local forms.

Occupational Therapy: As established in naval hospitals, occupational therapy is a form of treatment and not a diversional activity. Four of the five hospitals maintain occupational therapy shops which are adequately equipped to treat a large number of patients. There is also a Red Cross arts and skills shop at all hospitals. Although there is, theoretically, a clear-cut distinction between occupational therapy and arts and skills activities, it is almost impossible to differentiate between these two activities at naval hospitals, even though one is supposed to be medical and the other purely diversional. To illustrate, occupational therapy on the wards is under the jurisdiction of the Red Cross, and not the occupational therapy shop. The type of work performed overlaps to the extent that there is open conflict in one hospital and a distinct rivalry in other hospitals where the two establishments are maintained. Occupational therapists believe that the arts and skills activity infringes upon their field of operation.

Even in large hospitals there are only a small number of cases referred to occupational therapy for treatment. The total activity does not appear to justify their maintenance, and of that total a considerable portion is not of a therapeutic nature, but is primarily concerned with producing finished articles of practical or decorative significance. The survey team was informed that materials procured for occupational therapy shops are occasionally diverted to the use of personnel attached to the hospital staff rather than used in connection with the treatment of patients. This situation indicates that serious consideration

should be given to the discontinuance of separate occupational therapy shops in hospitals, especially where Red Cross arts and skills facilities are available. An occupational therapy technician located physically in arts and skills could direct the activities of patients requiring prescribed treatment. When this recommendation is adopted, considerable economies will be realized in operating costs, both for personal services and material. The quality of patient treatment will not be jeopardized since very few patients are referred for treatment, and friction between Navy staff personnel and Red Cross personnel will be materially reduced. In any event, when these shops are maintained, they should be directed by civilian technicians rather than nurses in order to relieve the nursing shortage which is now acute in the hospital establishment.

Physical Training: Physical training is a component part of the rehabilitation service. Actually, it no longer exists due to the demobilization of specialized personnel who directed physical training activities during the war.

Educational Service: The primary purpose of the educational service, a subdivision of the rehabilitation service, is to fulfill the patient's needs and desires in connection with his civilian educational status. United States Armed Forces Institute courses are administered, and schools and colleges are contacted to establish scholastic credits and obtain diplomas. San Diego is the only hospital attempting to maintain a full-scale program. There is a definite system in operation to insure that a large percentage of the patients contact the education office. At other hospitals practically all visits are on a voluntary basis, except for discharged personnel.

Most of the functions performed by this service can and should be discharged by the Veterans Administration representative located at Navy hospitals to assist and advise personnel returning to civilian life. Veterans Administration representatives did perform all educational work at one hospital. Patients who are not being discharged are usually hospitalized for only a short period of time and then returned to duty. It is questionable whether the hospitals should attempt to render service to this type of patient, since the responsibility should be assumed by his regular duty station. There appears to be little necessity for a large scale educational service program in peacetime naval hospitals. In addition, practically all qualified education officers and assistants have been demobilized. The welfare officer should be capable of performing any phase of the program that should be retained for both patients and staff. It is therefore recommended that the welfare and



recreation officer be assigned responsibility for the educational services on a collateral duty basis and that the activity be integrated with his organization.

Rehabilitation Desk (Work Detail Desk): Although the rehabilitation desk is not included in the rehabilitation service organization as established by the Bureau, it is one of the most important phases of rehabilitation in each hospital. In fact, at two hospitals the rehabilitation work detail function is the most active element in the whole program. The primary responsibility of this desk is to interview and assign patients to an activity within the hospital in order to keep the patient constructively occupied, prevent hospital fatigue, speed his convalescence, and at the same time assist with the routine hospital work-load. It is strongly believed that if this function is administered effectively, material benefits will be derived by both the patient and the hospital. At present the rehabilitation desk is under the jurisdiction of the master-at-arms. In another part of this report, it is recommended that the operation be assigned to the military personnel office, since the function of proper job placement in accordance with the needs of the individual and the hospital is logically the responsibility of the personnel officer.

Although hospitals are employing rehabilitation details, the best results are not being obtained primarily because of the procedures employed, and failure to assign a well qualified person permanently to the rehabilitation desk. The following procedure is recommended to assist in accomplishing the objective of this desk.

1. Ward medical officers classify each patient within 72 hours after admission and re-classify him thereafter as his condition warrants. The classification as published in BuMed ltr of 23 Oct. 1944 is too refined, and is not adhered to at any hospital. The number of classifications should be reduced from five to two, or possibly three. Class I would include both those patients with no physical activity limitations and ambulant patients with limitations as specified by the doctor. Class II would include those patients confined to bed or ward.
2. The ward doctor initiates the preparation of a form for all Class I patients indicating the activity restrictions, if any.
3. Sends patient, with completed form, to rehabilitation desk where patient is interviewed and assigned to appropriate detail.
4. Rehabilitation clerk prepares, concurrently, a rehabilitation card for the patient. Patient keeps this card in his possession at all times, and has it signed daily by

the supervisor of the activity to which he is assigned. No liberty shall be granted Class I patients who fail to report to their supervisor or perform duties as assigned. It is extremely important that a capable person be in charge of the rehabilitation desk since he must not only serve the best interests of the patients, but must also receive full cooperation of the wards if most satisfactory results are to be obtained.

Civil Readjustment: The civil readjustment function is rapidly decreasing, since most of the patients are being returned to duty and are not being discharged to civilian life. It is therefore recommended that civil readjustment be removed from the rehabilitation service and assigned to the personnel division.

Since the above analysis of the various activities constituting the rehabilitation service indicates that peacetime operating conditions do not warrant its retention as one of the professional services, it is proposed that it be removed from the organization chart.

#### RECOMMENDATIONS

1. Instead of being grouped together with a rehabilitation service, the rehabilitation functions which are retained should be reassigned to other appropriate units within the hospital organization. Peacetime operations do not warrant the retention of the rehabilitation service as a separate professional service.
2. The physical therapy function should be reassigned as an added activity in the orthopedic service under the chief of surgery.
3. In those general hospitals which have a Red Cross arts and skills shop an occupational therapy technician should be physically located in the arts and skills shop to service the few patients requiring therapeutic treatment, and occupational therapy shops should be discontinued.
4. If it is determined that the occupational therapy shop should be retained and that physical therapy shall not be a part of the orthopedic service, a physical medicine service should be established comprising both occupational and physical therapy.
5. Civilian technicians instead of nurses should be assigned to the physical therapy activity to relieve the current nurse shortage.
6. The Request for Special Examination and Treatment, NAVMED-HF-57, should be used in lieu



of local forms in requesting physical therapy treatment.

7. Responsibility for the educational service should be delegated to the welfare and recreational officer as collateral duty.
8. The advisory service for discharges now performed by the education office should be assumed by the Veterans Administration representative located at the hospital.
9. The five classifications for patients should be reduced to two or possibly three. Class I would include both those patients with no physical activity limitations and ambulant patients with limitations as specified by the doctor. Class II would include those patients confined to bed or ward.
10. An effective rehabilitation desk should be established in the military personnel office with a well qualified person in charge. This desk should not be under the jurisdiction of the master-at-arms, as at present.
11. The procedure recommended herein should be adopted to assure the successful operation of the rehabilitation desk.
12. The civil readjustment function should be assigned to the personnel division.

VII FOLLOW THROUGH





## FOLLOW THROUGH

The recommendations which are contained in this report fall into two broad categories:

- (a) Those which can be implemented immediately after approval by the Bureau.
- (b) Those which will require a test period in a hospital prior to adoption during which time they will be subject to revision and refinement.

The recommendations concerning personnel administration and organization belong, in general, in the former category; while most of the procedural and work measurement recommendations fall in the latter.

It is recommended that the Surgeon General and the BuMed Policy Board review and comment on the major aspects of the report prior to the adoption of any recommendations. It is important that a decision be made as early as possible concerning the advisability of effecting various recommendations in the report. Of primary importance are the procedural recommendations, since these recommendations must be installed in one or two hospitals for a trial period of approximately six months before final standard procedures for naval hospitals can be devised.

The recommendations which the Bureau approves should be incorporated into the overall program for standardization and improvement of naval hospital administration which the report proposes. Such a large program must be evolutionary rather than revolutionary if it is to be successful. Proper timing in implementing the approved recommendations, therefore, is of vital importance. In order to avoid confusion and obtain the most satisfactory results, changes should be made gradually in order of their significance. The first step is to set up a tentative schedule for the implementation of each recommendation. Then Bureau directives should be prepared and issued to the hospitals for those recommendations which should be effected without delay.

It would be advisable to run tests of the new procedures and some of the organizational changes in two hospitals, one large (1000 - 1400 patients) and the other medium size (400 - 650 patients). The hospitals selected should be fairly representative of their groups and not too far distant from the Bureau, so that close liaison can be maintained between the test hospitals and the Bureau during the trial period. It is also extremely important that the personnel at the hospitals selected show an active interest in the program and take an active part in the work. It would be desirable to place one officer at each hospital, pre-



ferably the personnel officer or one of his assistants, in charge of installing the recommended procedures. The Bureau representatives should work closely with this officer.

The personnel and records procedures proposed in the text of the report and the appendix undoubtedly contain several flaws which can be ironed out during the trial period. Every phase of the procedures should be subject to close scrutiny and procedural steps revised and refined as necessary. During this period local reports and forms in use at the test hospitals should also be analyzed more thoroughly and specific recommendations concerning the need for each should be made. At the end of the six month's trial period, final standardized procedures for naval hospitals should be developed and a procedures manual issued eventually as a guide for all hospitals.

Work measurement standards should also be tested for several months and revised on the basis of this test period. It should be emphasized that the staffing standards which are proposed are tentative, and will, of necessity, be subject to continual revision as the program progresses to keep standards in line with altered conditions. As far as possible, standards should be applied and their effectiveness developed by personnel within the particular hospital activity or operation being measured. Bureau personnel should act only in an advisory capacity. Within six months to one year standard staffing requirements should be issued to all hospitals. In the meantime, all hospitals should maintain complete work load information based on the proposed new standard organization and submit such data to the Bureau periodically.

The individuals who worked on the survey and who are still with the Bureau should work very closely with the pilot hospitals and the divisions within the Bureau which are concerned with the particular phase of the survey being studied during the installation period.

APPENDIX I

PROPOSED STANDARD PROCEDURES FOR WARDS AND PERSONNEL DIVISION





## CONTENTS

<u>PROPOSED STANDARD PROCEDURES FOR WARDS AND PERSONNEL DIVISION</u>	<u>Page</u>
Summary of Types of Patients	361
Admission Unit, including Distribution and Use of Admission Card	363
Bag Room	366
Ward	368
F Card, Change of Diagnosis, and Morbidity Report Desk	375
Form 10 (Daily Personnel Report) Desk	377
Form 36 (Ration Record) Desk	379
Health Record Custody Desk	380
Medical Survey Desk, including Distribution of NAVMED-M	381
Medical History Write-up Desk	386
Supernumeraries Desk; Checkage of Subsistence for Retired Navy & Marine Officers	387
Veterans Administration Desk	391
Enlisted Patient Receipt Desk (Navy and Marine)	394
Enlisted Patient Transfer Desk (Navy and Marine)	397
Discharge Desk	401
Officer Patient Desk	404
Death Desk	407
Serious and Critical List	410
Leave Desk	411
Personnel Accounting Desk	413
HC-3 and HC-4 (Status Reports) Desk	415
Detail Desk	417
Staff Officer Desk	419
Receipt, Transfer, Discharge, and Re-enlistment Desk (Staff Enlisted) (including Reports, Letters, and Forms)	422





## SUMMARY OF TYPES OF PATIENTS

(Before listing the operational step-by-step proposed standard procedures, the following outline is presented as a summary of types of patients received in naval hospitals. Included are the requirements for admission, proof of eligibility, authority, identification, etc. This information will assist in identifying data in the procedures that follow.)

1. Navy Enlisted patient reports from previous activity with NAVMED-G (Hospital Ticket), Health Record, Service Record, Pay Account, Continuous-service Certificate, letter of transmittal (of records) and baggage.
2. Marine Enlisted patient reports from previous activity with NAVMED-G (Hospital Ticket), Health Record, and baggage.
3. Navy Officer patient reports from previous activity with NAVMED-G (Hospital Ticket), Health Record, Pay Account, and official orders.
4. Marine Officer patient reports from previous activity with NAVMED-G (Hospital Ticket), Health Record, and orders.
5. Navy or Marine Enlisted or Officer personnel report from terminal leave with NAVPERS-553 "Notice of Separation" or terminal leave (separation) orders, in the event of necessary hospitalization.
6. Navy or Marine Enlisted or Officer personnel report from authorized liberty or leave for emergency treatment, with "Leave" papers, liberty card, or Navy/Marine Identification Card.
7. Supernumeraries report from home, place of occupation, previous activity (in case of other service personnel), etc., with proper identification, or authorization for hospitalization from the proper agencies, as follows:
  - a. Active Army Personnel - request from commanding officer of particular activity.
  - b. Coast Guard, Coast and Geodetic Survey, Merchant Marine, Maritime Service Personnel - request from U.S. Public Health Service on Form 1971F, Hospital Admission Card.

Coast Guard personnel admitted without this authorization may be retained; however the hospital will complete Coast Guard Form NCG-2522 which is an application to the U.S.P.H.S. for authority subsequently to be received on U.S.P.H.S. Form 1971-F.

Merchant Marine, Coast and Geodetic Survey, and Maritime Service personnel admitted without Form 1971-F: an affidavit is furnished these personnel for completion; after notarization by the Red Cross, this affidavit is forwarded to U.S. Public Health Service, who, in turn, furnish Form 1971-F.
  - c. Employees' Compensation Commission Personnel - ECC Forms CA-16, CA-17, and CA-20.
  - d. Retired USN, USMC, Retired (with pay) USNR, USMCR Officers, retired USN, USMC Enlisted, Fleet Reserve USN classes F-4 and F-5, Fleet USMC Reserve classes LB, LC and LD, Naval Pensioners-proper identification cards or continuous-service certificates.
  - e. Veterans Administration Personnel - Forms P-10, Application for Hospitalization or Domiciliary Care or VA-2557, VA-7522, VA-7501, signed by an accredited Veterans Administration representative.
  - f. Army Retired Personnel - identification card.
  - g. Navy Selectee Personnel - request from commanding officer or authorized representative of recruiting station.



- h. State Department Foreign Service Officers - presentation of proper credentials.
- i. Military Personnel of Foreign Nations, Embassy and Naval Mission Personnel, Prisoners of War - Letter of request or authority from commanding officer or consular liaison officials.
- j. American Red Cross, Federal Bureau of Investigation Personnel - proper credentials.
- k. Dependents of Navy, Marine Corps and Coast Guard personnel, including personnel of the retired list and fleet reserve - presentation of NAVMED-562, Dependents' Identification Card, or (in emergencies) local commissary card or current allotment check.
- l. Civilians - emergency or humanitarian cases - at discretion of commanding officer.

Note: This outline concerns only proof of eligibility, authority and required documents for admission.

PROPOSED STANDARD ADMISSION UNIT PROCEDURE

1. Patient enters admission unit (main or dependents' service) for hospitalization with proper records, orders, identification, authorization, official request, or under the category "Civilian Humanitarian" (at discretion of commanding officer).
2. Medical Corps officer on duty checks NAVMED-G, Hospital Ticket, and Health Record for diagnosis; if necessary, patient is re-examined. Admission clerk with approval of the medical officer, assigns ward in accordance with local assignment procedures.
3. Admission corpsman makes entry in NAVMED-HF-39, Patients' Register. Numerical sequence is used on new cases; "repeat" cases are entered as admitted, and former case numbers used. Entry is made in alphabetical section of "Patients' Register". ("DU" cases are entered in pencil, to be entered in ink with final diagnosis at time of discharge.)
4. Types Admission Card (7 copies) as follows:
  - 1 - Ward Copy
  - 2 - Information Desk Copy (Master Locator File)
  - 3 - Record Office Copy (Form 10 Desk)
  - 4 - Record Office Copy (F Card and Health Record Custody Desk)
  - 5 - Record Office Copy (Supernumerary, Veterans Adm., Officer Patients, Navy and Marine Receipt Desk, Staff Officer, Staff Enlisted Desks, as appropriate.)
  - 6 - Post Office Copy (Mail Directory Service)
  - 7 - Admission Unit Copy (Desk File)
5. Stamps patient's jacket, as follows:

Jacket # \_\_\_\_\_ (patient's register number)  
Name of Patient \_\_\_\_\_  
Rank/Rate/Classification \_\_\_\_\_  
Date of Admission \_\_\_\_\_  
Date of Discharge \_\_\_\_\_
6. Enters receipt of official documents accompanying patient in records office log as follows: (Items received marked "X"; those not received marked "O").

Name	Rate	File/Ser. #	HR	PA	SR	CSC	NAVMED-G	Letter of Trans.	Rec'd. (Initial)
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
7. Patient leaves for ward with #1 copy of Admission Card.
8. Corpsman types NAVMED-HF-22, Personal Effects Tag, including File/Ser. # of patient and number of metal seal. Types seal number on "Form G". A metal seal is applied to the baggage if not already sealed. Secures NAVMED-HF-22 (tag) to baggage. If patient is ambulatory, gear is taken by him to bag room; if a "stretcher" patient, gear is delivered to bag room by an ambulance driver or admission corpsmen. NAVMED-G accompanies gear to bag room.
9. Each morning at 0800, admission record clerk delivers official documents accompanying all patients to records office. Delivers the Health Record to the F card desk, the balance to the Navy and Marine receipts desk, or as appropriate. The receiving clerk initials for the documents as a receipt.
10. Admission corpsman distributes Admission Card copies and sends patient's jacket to central files.
11. Prepares a memo for staff personnel placed on sick list through 2400 the previous day. (Distribution: CO, XO, Staff Enlisted Desk, Staff Detail Desk, Staff Officer Desk, Chief Nurse's Office, as applicable).



12. "Prisoner" patients reporting for hospitalization under guard, via OOD, enter the admission unit escorted by the disciplinary ward corpsman. The regular admission procedure is followed as above. A memo is prepared for the CO, chief MAA, and disciplinary action desk regarding the physical examination given the prisoner patient by the medical officer. The memo includes disciplinary status, charges, summary of examination, and the statement "Patient was examined this date and found fit for confinement", with signature of medical officer on duty.
13. "Prisoners-at-large" reporting for hospitalization are admitted under the regular admission procedure. The security officer is notified of details by telephone.
14. The duty stations of emergency admissions (Navy and Marine personnel) are notified, and a notation is made on the Admission Card.
15. Each day Form 10, Daily Personnel Report, is received from the records office. The admissions for the previous day are checked against the desk file copies of the admission cards. Discharges are recorded in the patients' register, including "ink" entries on the "DU" cases.

#### DEPENDENTS SERVICE

16. #2, #3, #4 copies of the Admission Card on dependents are received by the main admission unit each morning at 0800. Admission information entries are then made in NAVMED-HF-39, Patients' Register, in the same manner as item 3. (The dependents' service admission unit previously receives either "blocks" of serial numbers for case number assignments daily, or issues numbers via 'phone upon admission of dependents.)
17. Admissions corpsman delivers #2 and #3 copies to the information desk, and Form 10 desk together with admission unit distributions. #4 Copy is retained in the main admission unit as a desk file copy.

## DISTRIBUTION AND USE OF THE PROPOSED STANDARD ADMISSION CARD

### Original (#1 copy) - Ward

The #1 copy of the Admission Card is taken to the ward by the patient or immediately forwarded by the admission unit. The ward copy of the Admission Card is used as a ward muster card, and contains information to aid the ward medical officer and ward nurse in the preparation of the clinical chart for subsequent medical treatment. In addition, it acts as an official "check-out" slip at the time of the patient's discharge.

### #2 Copy - Information Desk

The information desk receives the #2 copy at the beginning of the day's work following the day of admission of the patient for hospitalization. It is immediately filed in a visible Kardex file, and provides reference and current information regarding the location of a patient. The ideal hospital set-up would be to have only one central locator Kardex file in the information desk area, but the physical layout of most hospitals prevents this.

### #3 Copy - Records Office, Form 10 Desk

The #3 copy is forwarded each morning to the Form 10 desk in the BuMed Section and supplies immediate accurate information for the compilation of the Daily Personnel Report, Form 10, which is prepared at all hospitals for local use. The Form 10, which is distributed widely among the various activities in the hospital, includes the most important general features of the Admission Card. At the time of discharge of a patient, this copy of the Admission Card provides the basic discharge information to be included in the daily personnel report.

### #4 Copy - Records Office, F-Card Desk

The #4 copy furnishes information for the preparation of the Individual Statistical Report of Patient ("F" Card) relative to diagnosis, diagnosis number, key letter, specialty letter, details on case history, aviation status, and other vital statistics. After it has served its purpose at the F-card desk, this copy is forwarded to the Health Record custody desk. The Health Record custody desk prepares duplicate "tally" or receipt cards for a perpetual file check on the location of the Health or Service Record during the patient's hospitalization. If necessary for references purposes, this copy may be forwarded to central files for inclusion in the patient's jacket during hospitalization.

### #5 Copy - Records Office - Supernumeraries, Veterans Administration, Officer Patients, or Navy and Marine Enlisted Receipt Desk

The #5 copy is forwarded immediately, each morning, to the desk engaged in records activities on a specific category of patients. It is used as the desk file copy during the hospitalization of the patient. In the case of Navy and Marine enlisted personnel, it serves as a muster card in connection with Bureau of Naval Personnel reports and records.

In connection with supernumeraries, the information on the Admission Card furnishes specific important data regarding supernumeraries' eligibility and authority for hospitalization, in addition to various other important items, such as government insurance data, beneficiary, next of kin, details on injuries, mode of transportation, and other pertinent information for possible compensation. This information is also used in connection with staff officer and enlisted personnel.

### #6 Copy - Mail Directory Service

The #6 copy provides information regarding the location of a patient to facilitate mail distribution, which is an extremely significant morale factor.

### #7 Copy - Admission Unit

The #7 copy is retained by the admission unit as a reference file copy. Valuable information regarding a previous admission can often be obtained by retaining a three month "current" file of admissions.



## PROPOSED STANDARD BAG ROOM PROCEDURE

### RECEIPT OF BAGGAGE

1. Personal effects, with NAVMED-G (Hospital Ticket) are received in bag room.
2. Bag room clerk assigns bin or rack number, and enters data on NAVMED-G and Personal Effects Tag, NAVMED-HF-22.
3. Gives detachable portion of tag to patient (or delivers subsequently to patient on ward, if a bed patient).
4. Files hospital ticket alphabetically for control purposes: check-in and out of items, etc.
5. Stows baggage in assigned space.

### TO DEPOSIT OR WITHDRAW BAGGAGE

1. Patient reports to bag room on designated days with NAVMED-HF-22 stub. Corpsman removes baggage from stowage space and delivers to counter. Patient breaks metal seal and additional items are placed in or removed from baggage in presence of corpsman. NAVMED-G is pulled from file.

(A memorandum, signed by the ward medical officer or nurse, designating a ward corpsman to add or remove items for a bed patient, will be accepted for action by bag room personnel.)

2. Bag room corpsman enters additional items, or deletes items of gear on face of NAVMED-G. Patient initials for each item.
3. Corpsman draws line through old seal number on NAVMED-G, NAVMED-HF-22 stub, and tag secured to baggage, and enters new number on each. Returns stub to patient. Reseals bag.
4. Replaces bag in stowage space. Refiles NAVMED-G (with memo designating corpsman to act, if for bed patient).

### ISSUANCE OF BAGGAGE

1. Bag room corpsman receives "Duty Party" list, showing prospective daily discharges, from record office 24 hours prior to departure of patient.
2. Pulls NAVMED-G, Hospital Ticket, from files, and places in tray on counter, awaiting arrival of patients.
3. Removes personal effects from stowage space and places them in bin, area, or rack convenient to counter in order to eliminate delay in delivering baggage to patients being discharged.
4. Patients arrive, produce ward copy of Admission Card (for "check-out" procedure), identification card and baggage stub (NAVMED-HF-22). Corpsman checks off "Duty Party" list for patients' baggage to be issued.
5. Corpsman enters disposition of patient on NAVMED-HF-22 (tag). Patient signs for baggage received, on reverse side of NAVMED-G, which is then witnessed by bag room corpsman. Bag room corpsman initials ward copy of Admission Card under "Bag Room", to substantiate delivery of personal effects to patient.
6. Staples together the NAVMED-G, NAVMED-HF-22, tag and stub, and sends all to central files to be included in patient's jacket.

#### DEATHS

1. Master at arms inventories all of deceased's effects on ward. Bag room corpsman breaks seal on deceased's personal effects and inventories items. Forwards inventory to care of dead desk (records office) for continuation of death procedure. Delivers personal effects to Master at arms.
2. Notes NAVMED-G, Hospital Ticket, accordingly. Sends NAVMED-G to central files for inclusion in patient's jacket.

#### ISSUANCE OF BRIG PATIENT BAGGAGE

No withdrawals or additions to gear, by a brig patient are permitted. Master at arms authorizes release of baggage at time of discharge. Otherwise procedure is the same as for regular patients.



## PROPOSED STANDARD WARD PROCEDURE

### Admission of Patient to Ward

1. Patient reports with one copy of admission card.
2. Ward nurse assigns bed and prepares bed tag or identification card.
3. Prepares patient's chart or folder, including:
  - a. NAVMED-Q, Clinical Chart, one copy.
  - b. NAVMED-HF-17, Clinical Notes, one copy. Posts general admission notes.
  - c. NAVMED-HF-59, Clinical Record, one copy. Medical officer prepares in longhand. Log of patient's condition, examinations, laboratory findings, treatments included chronologically.
4. Posts pertinent information in admissions log, nurse's log, ward report, ward bed roster, diet sheet, and TPR (temperature, respiration and pulse) book.
5. Notifies ward medical officer of patient's admission.
6. Files copy of admission card alphabetically in Kardex or card file.
7. Corpsman prepares memo of valuables turned over to ward medical officer or nurse. Inventories valuables which are delivered by ward medical officer or O.O.D. to disbursing officer, who places them in a safe and prepares NAVS&A-555, "Official Receipt" for patient.

### Interward Transfers. (TOW - transferred to other ward)

1. Ward nurse transferring patient notifies receiving ward nurse by telephone.
2. Transferring nurse completes patient's folder and chart and makes entry regarding transfer in NAVMED-HF-17, Clinical Notes.
3. Patient or corpsman delivers clinical folder to nurse on new ward. One copy of admission card and bed or identification tag accompanies patient.
4. Nurse removes patient's name from special diet sheets (if any). Makes TOW entry in nurse's log, disposition entry in admissions log, entry on NAVMED-HF-9 (Ward Report), and revises ward bed roster.

### Interward Transfers. (AOW, admitted from other ward).

1. Receiving nurse receives call from transferring nurse regarding patient's transfer.
2. Patient reports with clinical folder, copy of admission card, and bed or identification tag.
3. Nurse assigns bed.
4. Reviews patient's clinical folder or chart for completeness, and makes transfer note entry on NAVMED-HF-17, Clinical Notes.
5. Same as items 4, 5, and 6 in "Admission of Patient to Ward" above.

### Ward Reports, NAVMED-HF-9

1. Nurse prepares 3 copies of report: original to records office, second copy to Information Desk, and third copy to mail directory.
2. Signs report covering 24-hour period, commencing at midnight.

3. Lists four groups - admissions, dispositions, serious and critical list patients, and absentees; allowing space for entries in each chronologically.
4. Posts such data as name, rate and time of departure of all AOL, AWOL, and leave (other than convalescent) patients. Specifies branch of service, e.g. USN, USMC, USA, after "Rank".
5. Indicates, as occupying a bed, patients on leave (other than convalescent leave), in brig, or in AOL or AWOL status. Patients who have been AOL or AWOL for thirty days and then discharged, are accounted for by noting "Ran" on report.
6. Carries officer patients who are subsisting out on census, but are not shown as occupying a bed.
7. Indicates in the upper left margin of the ward report the number of patients in the following categories:
  - a. On leave (not convalescent leave).
  - b. AOL.
  - c. AWOL.
  - d. Brig.
  - e. Subsisting Out (officers, shown as USN, USNR, USMC, etc.).

Laboratory Examinations, NAVMED-HF-27.

1. Medical Officer signs requests on left side of form.
2. Sends ambulatory patients to laboratory with requests, according to laboratory schedule. Bed patients' requests are delivered to laboratory by messenger. The notation "Strict Bed Patient" and the location of patient's bed on ward appears on request. Emergency requests must be so marked. (Routine laboratory examinations are initiated by the admission unit.)
3. On return of NAVMED-HF-27 with findings entered, nurse pastes form on blank sheet and places in clinical folder.

Special Examination and Treatment Request, NAVMED-HF-57.

1. Submits all requests for special examination and treatment, including the following on NAVMED-HF-57:
  - a. Electrocardiograph.
  - b. Basal metabolism rate.
  - c. X-ray (including gastro-intestinal series, cholecystography).
  - d. X-ray therapy.
  - e. Physiotherapy.
  - f. EENT consultations, etc.
  - g. Occupational therapy.
  - h. Blood transfusion.
2. Medical officer signs NAVMED-HF-57.
3. Includes all available information in the request so that the patient will receive as much benefit from examination or treatment as possible.

Serious and Critical Lists.

1. Each hospital shall specify in the standing orders the procedure for placing or removing patients from serious and critical lists.
2. Ward medical officer is responsible for placing or removing patients from these lists.



3. Medical officer makes entry in patient's clinical chart, entry on ward report, and entry in nurse's log. Diagnosis must be determined in all serious and critical cases before entries are made.

Changes of Diagnosis, NAVMED-HF-53.

1. Medical officer prepares form in duplicate, using correct diagnostic nomenclature and diagnosis number. Extreme care should be exercised to include proper designations for evaluation in records office for F card procedures.
2. Ward corpsman delivers both copies of NAVMED-HF-53, together with patients chart, to "F" card desk in records office for change of diagnosis portion of "F" card.
3. Ward corpsman waits for completion of entry and returns with completed chart to ward.

Diet Sheet, NAVMED-HF-18.

1. For diet kitchen.
  - a. Ward nurse prepares and signs one copy daily. Names of all patients and special diets are listed thereon.
  - b. On wards where constant changes occur in special diets, nurse maintains rough files on each diet, and notes current telephone calls to diet kitchen which results in diet changes.
2. For commissary (nourishment or liquid diets).
  - a. Nurse prepares and signs one copy each for morning and afternoon nourishments. Corpsman reports to commissary and delivers items to ward.

Liberty List, NAVMED-HF-20.

1. Ward nurse prepares original and two copies of list for signature of medical officer. Original and one copy is sent to MAA, and other copy retained on ward.
2. Submits liberty list of patients on rehabilitation detail in duplicate to special detail office daily before 0830. (No VA patients are on this list.) Retains one copy of list on ward.

Request for Repairs, NAVMED-HF-63.

1. Ward nurse prepares and signs request for repairs when necessary. (This form is used for repairs to equipment, etc.)

Request for Supplies, (expendable), NAVMED-P.

1. Nurse prepares original and one copy for signature of ward medical officer. Submits when and as directed in standing orders. Submits emergency requests to executive officer at any time.

Request for Equipment (non-expendable), NAVMED-11.

1. Nurse prepares original and two copies for signature of medical officer. Retains last copy on ward.

2. Submits requests when and as directed in standing orders. Submits emergency requests to executive officer at any time.

Laundry List. NAVMED-HF-21.

1. Completes list for linen inventory on day designated in standing orders.
2. Counts linen on hand only, not linen due from linen room. Counts linen on ward before corpsman leaves for linen room.
3. Exchanges soiled linen for clean in quantities desired on days designated in standing orders.

Prescriptions. NAVMED-148.

1. Ward medical officer prepares and signs prescriptions.
2. Takes drug book to pharmacy at hours specified in standing orders except in cases of emergency.
3. Enters one drug on each prescription blank. Entries should be made in ink.

Ward Books and Logs.

1. Admission Book (or Log).
  - a. Ward nurse lists every patient admitted to ward, alphabetically.
  - b. Column headings are: Date Admitted, Name, Rate, Age, Weight, Height, Date of Discharge, and Disposition and Date.
2. Narcotics Book.
  - a. Nurse records narcotics received, chronologically.
  - b. Takes narcotic count, and records at each change of watch.
  - c. Column headings are: Date-Time, Name of Patient, Rate, Amount of narcotic administered, Name of Nurse. Medical officer who orders narcotic initials book.
  - d. Records in red ink, the receipt of narcotics from the pharmacy and summaries at each change of watch.
3. "TPR (Temperature, Pulse and Respiration) Book.
  - a. Nurse takes temperatures in accordance with standing orders.
  - b. Posts to clinical charts from entries in this book.

AM and PM Report. (Completed and signed by each AM and PM nurse and night corpsman.)

"Ward No."	"Watch: (Port or Starboard)"	"Date"
Previous census (Total)	Beds on ward (Total)	
Admissions (Total)	Occupied beds (Total)	
AOW (Total)	Vacant beds (Total)	
Discharges (Total)	Bed patients (Total)	
TOW (Total)	Sleepers (On other wards) (Total)	
Census at (Time)	Leave (Total)	
Census at (Time)	"Safe-keepers" (N.P. Wards)	



Corpsmen on Watch:

"Name"

"Rate"

"Watch: (Starboard Port Night)"

-----

Admissions: (Patients admitted during watch):

"Name"

"Rate"

"Diagnosis"

-----

Special Liberty:

"Name"

"Rate"

"Details"

-----

Special Medications: (Details: narcotics, hypnotics; digitalis, penicillin, etc.)

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Special Notes on:

1. Serious list and critical list patients with orders and full report, including special watch.
2. Pre-operative and post-operative patients with orders.
3. One-day orders; special new orders; laboratory work for night corpsmen to handle in morning.
4. Name and rate of PALs, GCMs, AOs, AWOLs, and patients on leave.
5. Patients requiring special observation.
6. Unusual happenings on the ward, e.g., money stolen, disorderly conduct of patients, etc.

(Night report by corpsman on watch is put on reverse side of page.)

Doctor's Order Book.

1. No medication or treatment is to be given, except in extreme emergencies, or unless the order appears in the doctor's order book and has been signed by the doctor.
2. Headings for each day should be: "A.M. Sick Call (date)", and "P.M. Sick Call (date)".

Miscellaneous.

1. Discharge to Convalescent Leave.

- a. Ward medical officer and chief of service approve requests for convalescent leave.
- b. At time specified by standing orders patient reports for discharge to records office (leave desk) with chart, change of diagnosis to "No Disease--Convalescent Leave", and one copy of admission card.
- c. Ward nurse records discharge in "AM-PM Report" log, admission book, and ward report (NAVMED-HF-9).

2. Admission from Convalescent Leave.

- a. Patient returns from records office with one copy of admission card and chart.

- b. Admitted to ward with diagnosis "No-Disease-Convalescent Leave".
  - c. Nurse records as new admission.
  - d. Ward medical officer prepares change of diagnosis.
3. Discharge Procedure.
- a. Ward medical officer prepares "ward disposition slip" ("duty slip" or memo) after deciding patient is ready for discharge or transfer. Nurse sends patient's chart to records office approximately one or two days prior to date of discharge.
  - b. Records office issues "rough" duty list to ward giving date of discharge and instructions.
  - c. Ward corpsmen instruct patients on ward in routine for discharge.
  - d. Records office completes "smooth" duty list received by ward.
  - e. On day before discharge patient checks out with officers listed on reverse side of one copy of admission slip, and obtains signatures.
  - f. No liberty is given on day prior to discharge.
  - g. Patient reports to records office on duty day with one copy of admission card.
  - h. Patient musters on duty day at designated areas in accordance with standing orders.
  - i. Patient's name is removed from all lists and discharge is reported in AM-PM report, ward report, and admission book.
4. Deaths
- a. Ward medical officer pronounces patient dead.
  - b. Notifies O.O.D. immediately by phone, stating time and causes of death.
  - c. Senior corpsman prepares 3 identification tags as follows: Ward, Full Name, Rate, Diagnosis, and Religion. Secures one tag to ankle of deceased, second to sheet wrapped around body, and third to patient's effects on ward.
  - d. Nurse or corpsman collects all effects of deceased and notifies MAA.
  - e. Medical officer and nurse close clinical chart and send to records office.
  - f. Nurse records facts regarding death, including exact time of death, in AM-PM Report and ward report. Notes death and disposition in admission book. Removes name of deceased from all lists.
  - g. Balance of procedure is as required by records office.
5. Prisoners-at-large.
- a. Ward nurse musters all patients in this status at 0800, 1200, 1600, 2000 daily, and in her absence, by the senior corpsman. Notifies the MAA immediately if a patient fails to muster.
6. Rules for Patients.
- a. Patients should be informed of routine rules upon admission.
  - b. Rules for patients depend on the standing orders of the hospital.
7. Clinical Charts
- a. Charts must be in order and current at all times.



- b. When patient's temperature-taking has been discontinued, it must be so indicated on temperature sheet. If medical officer discontinues bedside notes, this must be indicated on the clinical notes form.
- c. Any subsequent complaints by or medication to patients must be recorded on the chart.
- d. All medications, treatments, diets, symptoms, condition and any changes therein must be charted.
- e. When patient is transferred to another ward, transfer must be charted and dated and the ward to which patient is transferred must be recorded.
- f. The current sheet in clinical chart and clinical notes is always top sheet.
- g. All barbiturates, hypnotics, narcotics, penicillin, streptomycin, and digitalis must be charted as given.

PROPOSED F CARD, CHANGE OF DIAGNOSIS, AND MORBIDITY REPORT DESK PROCEDURE

F CARD

1. Admission unit forwards #4 copy of Admission Card and patient's Health Record to F card desk each morning.
2. F card desk clerk stamps NAVMED-H-8, Medical History (part of Health Record) to show "take-up" of patient as follows:  
U. S. Naval Hospital \_\_\_\_\_ Date \_\_\_\_\_  
F Date ..... Diagnosis No.....  
Diagnosis.....  
T Key #.....Spec. No.....  
Origin.....
3. Prepares temporary "take-up" data if emergency patient is without Health Record, NAVMED-H-8, and Abstract of Service, NAVMED-H-5.
4. Checks Health Record and Admission Card for discrepancies, and corrects admission information.
5. Prepares "F" and "Fa" cards from Admission Card and Health Record, in accordance with "F" card procedural manual. Furnishes misconduct information to the Health Record write-up desk for preparing misconduct reports.
6. Form 10 desk forwards Form 10 daily to F card desk. F card desk clerk checks admissions on Form 10 against "F" cards to ascertain and correct any discrepancies.
7. Checks duty party list (discharged to "leave" from NAVMED-HF-9, Ward Reports, at leave desk or Form 10 discharges). Pulls old "F" and "Fa" cards on discharged patients and closes out cards, in accordance with F card procedures.

CHANGE OF DIAGNOSIS

8. Wards forward NAVMED-HF-53, Change of Diagnosis, and Clinical Charts at designated hours during the day. Ward corpsman waits for entry to be made in chart and then returns to ward.
  - a. F card desk clerk pulls old "F" and "Fa" cards on change of diagnosis cases. Prepares new "F" and "Fa" cards. Stamps chart cover with change of diagnosis number. Inserts entry in red on NAVMED-HF-59, Clinical Record, part of chart, in chronological sequence. Indicates date, new diagnosis, and number of diagnosis.
  - b. Closes out old "F" and "Fa" cards to new diagnosis. Returns Clinical Chart to ward corpsman for delivery to ward.
9. Clerk or records officer initials closed-out "Fa" cards then mails to Bureau.
10. Prepares and maintains lists of all "diagnosis undetermined" cases. Ten days are allowed for general DU cases, 30 days for NP and tuberculosis cases, and none for staff. As changes take place, list is changed to conform. Prepares report at the end of each two-week period for XO and chiefs of services.
11. Reports communicable diseases to department of public health (State), as required locally. Prepares cards, etc., for record officer to sign.
12. Receives and posts information from genito-urinary section. Ward forwards information on V.D. contacts. Receives and posts information as to date and place of contact, and serial number of NAVMED-171, Venereal Disease Contact Report, in "Remarks" column of "F" card. In case of syphilis patients discharged, advises U. S. Public Health authorities in the particular area of proposed residence of patient by letter as to place of residence, etc.



13. Sends #4 copy of Admission Card and patient's Health Record to Health Record custody desk.
14. Sends all cards for day's work to morbidity report desk for further steps in procedure. Files Form 10 for reference.

#### MORBIDITY REPORTS

1. F card desk forwards "F" cards each afternoon to morbidity reports desk.
2. Clerk sorts "F" cards according to diagnosis number. Prepares worksheet to conform with the ninety-five different designations, by class of disability, in order shown on the printed form NAVMED- 582 (9-46). Enters each change or admission as a unit under columns headed "A" (admissions), "RA", "FI", etc.  
  
Enters information regarding disposition from the sick list similarly, from closed "F" cards for day's discharges. Entries are made in appropriate column, i.e., "D" (duty), "DD" (died), etc.  
  
Lists staff admissions by name on a separate worksheet, with diagnosis number, etc., to be used as a check against information received by staff enlisted desk, and staff officers' desk. (for double-check purposes)
3. Furnishes "K" casualty information to NAVMED-I (Weekly Report of Patients) desk. (Optional: If list is maintained at that desk, this is not necessary.)
4. Prepares NAVMED-172, Weekly Morbidity Report, from staff admission worksheet for week. Distribution: Sends BuMed 2 copies, and files 1 copy.
5. Prepares NAVMED-582, Monthly Morbidity Report, from totals of "take-up" worksheet daily units. Distribution: Sends BuMed 2 copies, and files 1 copy. One copy is prepared for staff, and one for transient personnel (patients).
6. Bed capacity and patient data, for Quarterly Report, NAVMED-103.
  - a. Prepares this report for finance office. However, data is received in form of quarterly ward report from all wards, showing detailed list of ward patients by name (alphabetically), date of admission, name, rank or rate, V. A. patient, etc., branch of service, diagnosis, and race.
  - b. Babies are not counted in this report, unless mother has been discharged and baby remains for treatment, whereupon baby is treated as a dependent.
  - c. Report shows number of beds occupied, or vacant, total number of sick days during quarter, total sick days of patients discharged, total patients admitted, total discharged, and total number of patients remaining at end of quarter as shown by Form 10.
7. Files active "F" cards alphabetically, by classification of patients. Files closed out cards numerically according to diagnostic nomenclature. Files Form 10 according to date.

**PROPOSED FORM 10 (DAILY PERSONNEL REPORT) DESK PROCEDURE**

1. Ward corpsman delivers Ward Report, NAVMED-HF-9, to Form 10 desk at 0800 daily.
  - a. Form 10 clerk arranges ward reports numerically by ward numbers, and checks to tally AOWs and TOWs.

- b. Makes recapitulations from combined ward reports on worksheets, as follows:

	<u>Remaining</u>					<u>Remaining</u>
<u>Ward #</u>	<u>Prev. Day</u>	<u>Admissions</u>	<u>AOWs</u>	<u>TOWs</u>	<u>Discharges</u>	<u>Present</u>

and,

<u>Ward #</u>	<u>Total Bed Capacity</u>	<u>Occupied Beds</u>	<u>Unoccupied Beds</u>	<u>Leave &amp; Subs. Out</u>	<u>AWOL AOL</u>	<u>Total Patients</u>
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2. Admission unit clerk forwards #3 copy of Admission Card at 0800 daily, including copy of Admission Card on dependents' service.

- a. Form 10 clerk separates copies of admission cards into following groups: Officers, Navy and Marine, Enlisted, Navy and Marine, Coast Guard EM, Supernumeraries, Veterans Administration Patients, Dependents. Checks admissions against ward reports.

3. Cuts stencil on detailed "admissions" (part of Form 10), listing all service personnel in their group, by rank and rate, alphabetically, each category separately. Births may be listed here also.

	<u>Rank/Rate</u>	<u>Branch</u>						<u>From Where</u>
<u>Name</u>	<u>or Classif.</u>	<u>Serv.</u>	<u>File/Ser. #</u>	<u>Jacket #</u>	<u>Relig.</u>	<u>Ward #</u>	<u>Diag.</u>	<u>Adm.</u>

4. Receives following memoranda at 0800 daily, regarding changes in patient status:

- a. Duty party list (including Marines) from record office transfer desk.
  - b. Dischargee list from record office discharge desk.
  - c. Supernumerary discharge list from supernumerary desk.
  - d. Veterans Administration discharge list from Veterans Administration desk.
  - e. Dependent and infant discharge list from dependents' service.
  - f. Patients to terminal leave, convalescent leave, from cognizant section.
  - g. Officer patients discharged from officer patients desk.

5. Receives following memoranda daily at 0800 regarding changes in staff personnel status: (received, detached, on sick list, temporary duty, commuted rations, under instruction, etc.)

- a. Staff officers, from staff officer section.
  - b. Staff nurses, from chief nurse's office.
  - c. Staff enlisted, from Hospital Corps personnel office, or detail desk.
  - d. Brig report, or security officer's report on absentees.

6. Clerk pulls admission cards on prospective discharges from visible Kardex file.

7. Checks memoranda on patient discharges against ward reports.

8. Cuts stencil on detailed "discharges" (part of Form 10), listing by rank and rate, alphabetically, all service personnel in their respective groups; also alphabetically all other categories, separately. (If separate stencil has been cut previously on Navy and Marine duty parties, notation to that effect, denoting omission of these names is recommended.) Infant discharges may be included separately, or together with dependents discharges.

	<u>Rank/Rate</u>				<u>Date</u>		<u>Disposition or</u>	<u>From</u>
<u>Name</u>	<u>or Classif.</u>	<u>Br. of Serv.</u>	<u>Ser./File #</u>	<u>Jacket #</u>	<u>Adm.</u>	<u>Diag.</u>	<u>Home Address</u>	<u>Ward #</u>

9. Prepares classification sheet of patient census for cover page of Form 10 from admission cards, and discharge information.

<u>Patient Classification</u>	<u>Remaining</u>			<u>Total</u>
<u>(Parts A, B, C of Form 36)</u>	<u>Last Report</u>	<u>Admissions</u>	<u>Discharges</u>	<u>This Report</u>



10. Cuts stencil on cover page of Form 10, including:
  - a. Bed census from particular worksheet.
  - b. Patient classification and census from memoranda.
  - c. Staff, other than those appearing on staff and supernumerary census (including veterans) from memoranda.
11. Mimeographs Form 10, assembles and distributes.
12. Posts interward transfers (AOW and TOW) daily to visible Kardex. (Received daily from all wards.)
13. Checks periodic "sight" musters against visible Kardex from detailed ward reports received as to patients on ward.
14. Files #3 copy of Admission Card daily, alphabetically, in visible Kardex.
15. Maintains all worksheets and memoranda in respective files at desk in chronological order.
16. Pulls #3 admission cards on discharges and maintains for three months at visible Kardex section in alphabetical order.

# PROPOSED FORM 36 (RATION RECORD) DESK PROCEDURE

1. Form 10 desk forwards daily personnel report to "Form 36" desk each morning.
2. Form 36 clerk maintains file cards (3 x 5) on all officer patients, regarding subsistence data.
  - a. Prepares cards as follows:
 

Name	Rank	File No.	Pay Account Carried	Date Subs. Out Begun	Date Subs. In Began
_____	_____	_____	_____	_____	_____
  - b. Maintains cards in two categories: (1) Subs. Out; (2) Subs. In.
  - c. Subdivides categories further into groups: USN, USNR, USN RET'D, USMC, USMCR, OTHER (WAVES, Nurses, etc.)
3. SOQ forwards memoranda daily regarding changes in category of patient.
4. Receives memoranda for further information and subsistence data as follows:
  - a. Daily Census of Nurses - from chief nurse.
  - b. Report of Hospital Corpsmen - from Hospital Corps personnel office.
  - c. Daily Census of Staff Officers - from staff officers desk.
  - d. Personnel Report - from Hospital Corps school (if any).
  - e. Enlisted Patients on Leave (subs. out) - from record office.
  - f. Civil Employees (subs. in) - from finance office (civil employees).
  - g. Brig & Locked Ward Report - (GCM prisoners) - from security officer.
5. Prepares sections A, B, C, D and E of daily Form 36 from Form 10, officer patient card files, and above-mentioned memoranda.
6. Prepares Hospital Ration Notice, NAVS&A-534. If pay accounts of officer patients is carried locally, disbursing officer receives two copies, third is for patient's jacket. If carried elsewhere, two copies are forwarded to that activity, and third is retained for patient's jacket. Prepares NAVS&A-534 on each officer admitted, on patients subsisting out, on patients on leave, and on patients discharged.
7. Prepares Form 36, Ration Record, from recapitulation of daily reports. In addition, sections F and G are prepared as follows:
  - a. Part F - Rations Sold; monthly report is received from commissary.
  - b. Part G - Status of Local Collections; report is received from agent cashier monthly on collections from supernumeraries and dependents.
8. Types Form 36 monthly for distribution as follows:
 

Original	-	Bureau of M & S
#2 copy	-	Finance Office
#3 copy	-	Central Files
#4 copy	-	Form 36 Desk File



## PROPOSED HEALTH RECORD CUSTODY DESK PROCEDURE

### ADMISSIONS

1. F card clerk forwards Health Record and #4 copy of Admission Card to Health Record custody clerk.
2. Custody clerk rechecks Health Record for missing sheets, proper entries, etc.
3. Enters information in bound log with pertinent data to facilitate obtaining Health Record from previous commands on patients admitted without original Health Record. Log contains the following information:  
Date Adm.   Name   Rate   Ser. #   Rec'd. From   Date HR Req.   Date HR Rec.  
\_\_\_\_\_
4. Prepares receipt or tally cards for Health Records received. (also for those records not received with note regarding request.)
5. Forwards letter to patient's command requesting Health Record of patient. Distribution: Sends original and #2-command and files #3 copy. Notes request on Admission Card; uses file copy as tickler followup.
6. Receipts and mails letter of transmittal from command. Notes this on Admission Card.
7. Files #4 copy of Admission Card after it serves purpose.

### DISCHARGES

1. Transfer desk forwards rough duty list and clinical chart.
2. Custody desk clerk checks Clinical Chart for all entries, change of diagnosis, corrections, etc.
3. Pulls Health Record and delivers to medical history write-up desk for completion.
4. Completes NAVMED-H-8 and Medical Abstract, NAVMED-H-5, if health records are not received.
5. Receives Health Record from write-up desk, completed. Obtains signature of ward signature of ward medical officer and chief of service.
6. Completes Clinical Chart and Health Record currently. Files them temporarily until leave is completed for convalescent leave patients.
7. Completes Health Record and Clinical Chart to date for medical survey patients on terminal leave. Files them temporarily until leave expires, at which time Health Record and Clinical Chart are pulled and sent to discharge desk for regular discharge procedure. The termination of Health Record, NAVMED-H-2, is completed also at the expiration of terminal leave before the Health Record is sent to the discharge desk. If "invalided from service", Health Record is forward to BuMed with "Fa" card.

### REPORTS

1. Clerk completes NAVMED-A, Annual Syphilis Report for the Year \_\_\_\_\_, annually from Health Records on board, as of 31 December. Includes Health Records containing NAVMED-H-7, Abstract of Antiluetic Treatment for report. (See Health Record custody desk portion of the report for the recommended elimination of this form, NAVMED-A.)
2. Prepares NAVMED-171, Venereal Disease Contact Report, when necessary. The distribution is according to instructions on the form.

# PROPOSED MEDICAL SURVEY DESK PROCEDURE

1. Ward medical officer prepares "rough" NAVMED-M, Survey Report, after deciding patient is ready for survey (Marine or Navy).
  - a. Receives information monthly from chief of service via record office on patients who have been hospitalized either locally or at other hospitals for (1) officers - 90 days, (2) enlisted - 6 months.
  - b. Sends aviation officers regarded fit for duty by ward medical officer to nearest air station for flight physical examination.
2. Sends "rough" survey to survey board recorder (junior member of three-man medical survey board).
3. Survey board meetings are held in accordance with local schedule, according to type of case to be considered.
  - a. Recorder requests Health Record, Clinical Chart, and other documents required by Board from records office or ward.
  - b. Patient is present at meeting, and is informed of recommendations made on basis of ward medical officer's clinical notes, chart, evidence, etc.
4. Recorder prepares a daily list of surveys upon which decisions have been rendered by the local survey board for medical survey desk.
5. Patient is sent to civil readjustment after notification as to survey. Patient then returns to ward. Forwards "Rough" survey and all documents, i.e., Health Records, Clinical Charts, etc., to medical survey desk.
6. Medical Survey clerk pulls patient's service record. Checks disciplinary action to determine whether local or medical survey. Checks Health Record for completeness and accuracy of all entries.
7. Survey clerk also checks all accompanying documents for completeness and accuracy. (Entries, signatures, rebuttal statements submitted by patients, decision of patient to waive rights before retirement board, and flight physical for aviation officers.)
8. Prepares survey file on each survey case reviewed by survey board as follows:

Name	File/Ser. #	Rank/Rate	Ward No.
Diagnosis			Diag. No.
Date Before Local Board	_____		
Recommendation:	_____		
Chief of Service	_____		
Local Board Members	_____		
	_____		
Local Action	_____		
Bul&S Action	_____		
Date Mailed	Date Received		
Action	HR Returned		
Remarks	Clin. Chart Ret'd.	_____	

9. Prepares memo to various activities listing names of patients who have appeared before board with following column heads:  
 Ward #    Name    Ser. #    Rate/Rank    Recommendation    Date Adm.    Adm. From
- Distribution: Civil Readjustment, Red Cross, F Card Desk, Marine Detachment, Educational Services Office, File.



10. Types NAVMED-M on basis of whether local approval or BuMed approval.  
Distribution: (depending on particular case).
11. Recorder stamps entry in Clinical Chart as follows:  
"Appeared before Medical Survey Board \_\_\_\_\_ (date). The following findings were established: diagnosis \_\_\_\_\_ Disability \_\_\_\_\_ is (not) of his own misconduct and was (not) incurred in the line of duty. \_\_\_\_\_ (Yes or No). Present condition \_\_\_\_\_ Probable future duration \_\_\_\_\_ Recommendation: \_\_\_\_\_."
12. Survey clerk transfers health records to medical survey write-up desk for medical abstract of survey, etc. Health Record is completed and returned to medical survey desk.
13. Clerk rechecks NAVMED-M and Health Record write-up for accuracy, sick days, and method of approval (local or BuMed).
14. Health Record remains at medical survey desk with Clinical Chart. Service Record is returned to file.
15. Board members sign NAVMED-M (form is sent for signature accompanied by rough survey). Clerk dates "M" and Health Record (NAVMED-H-8) entries. Sends original of "M" and Health Record to commanding officer for signature. (Also sends waiver original, and original of rebuttal, for reference by commanding officer during his review of "M" and Health Record for signature.)
16. Commanding Officer returns "M", Health Record, and additional documents. All endorsements are added.
17. Clerk sends copies of NAVMED-M for routing. Sends "M" to Navy transfer or discharge desk on local approvals.
18. Sends chart accompanied by a copy of NAVMED-M for ward medical officer's reference. If Bureau survey, "M" is noted as to date form was mailed to BuM&S. Chart is receipted for.
19. Retains Health Record at survey desk for ultimate disposition. (On all terminal leave cases, whether local or BuMed approval).
20. All NAVMED-M Bureau approvals are received from Bureau at medical survey desk. Memo is prepared of all BuMed approved surveys as follows:

Name	Rate	File/Ser. #	Recommendation	Action
Sends original and 1 copy to transfer desk. Copy is receipted and returned to medical survey desk denoting information received to facilitate discharge procedure.				
21. Makes entry on survey file index card as to receipt of approval. Date actually received is date used for ultimate disposition. Files index card as "inactive".
22. If BuMed returns survey report for any of various reasons, Board reconvenes, and decides on basis of Bureau recommendation.
23. Upon expiration of terminal leave of surveyed patient, removes Health Record from temporary files and forwards to Veterans Administration desk for photostating. Upon return, makes entry in NAVMED-H-8 as to pension claim.

DISTRIBUTION OF NAVMED-M, INSTRUCTIONS REGARDING SURVEYED PERSONNEL, ENDORSEMENTS, ETC.

OFFICERS (In all cases check for flight physical examination.)

1. Navy officers to limited duty or full duty (Bureau of Medicine and Surgery approval).

- a. Directs officer to report to permanent duty station for duty. (Applicable when officer's permanent duty station is ashore in local area.)
- b. Makes all other officers available to the commandant of district for assignment while awaiting action on report of medical survey.

Reference: BuPers Cir Ltr No. 133-44 (Corrected) 5 May 1944

2. Marine officers to limited duty or full duty (Bureau of Medicine and Surgery approval).

- a. Directs officer to report to permanent duty station for duty. (Applicable only when officer's permanent duty station is ashore in local area.)
- b. Directs all other officers to report to Coast Guard, U. S. Marine Corps Barracks, or nearest Marine Corps facility, as applicable.

Reference: Comdt. MarCorps ltr 1515-30-DFA-904-mm, dtd 27 March 1946.

3. Navy and Marine officers to inactive duty, to discharge from Naval Reserve, USMC Reserve, or to appear before Navy Retirement Board. (Bureau of Medicine and Surgery for approval)

- a. Patients remain on board as patients awaiting action by Bureau.
- b. If leave granted, clerk notes on survey file index card: "This officer granted (days) sick leave beginning (date). Address while on leave: \_\_\_\_\_." (If "no leave", notes on card.)

Reference: BuPers ltr P18-1/00 Pers. 319 CM dated 25 Sept 1946.

4. Mailing and Distribution:

Original and 3 NAVMED-M - Bureau of Medicine and Surgery  
1 Copy - Veterans Administration Desk (Except to duty)  
1 Copy - Patient Officer Desk  
1 Copy - SOQ  
1 Copy - Marine Detachment (Marine Officers Only)  
1 Copy - Central Files  
1 Copy - Desk File  
1 Copy (Extra) - In event request for copy for officer approved.

Endorsement: 1. To Bureau of Medicine and Surgery, Washington, D. C.  
Reference: (As pertinent, above.)

ENLISTED PERSONNEL: (Local Approvals)

1. Navy: Endorsement: "1. Approved,  
BuMed C/L 46-149."

Distribution: Orig. & 2 - Transfer Desk (This desk in turn sends original & 1 to BuMed;  
1 to Central Files).

1 Copy - Vets. Adm. Desk  
1 Copy - Ward  
1 Copy - Red Cross  
1 Copy - Desk File  
1 Copy - Health Record  
1 Copy - Transfer Desk (For Fleet Reserve transfer if retired Chief. In this case endorsement reference is "Para 3318.2(b) MMD, 1945."



2. Marine: Endorsement: "1. Approved  
MarCorps Bufiled Jt. Ltr. 1500-120 over DGK-112-dmah  
12 Sept. 1945."

Distribution: Original & 4 - Transfer Desk (This desk in turn sends original  
& 2 to Marine base activity where  
patient is to be discharged from  
service, also 1 to central files.

1 Copy - Transfer Desk (Marine transfer procedure)  
1 Copy - Ward  
1 Copy - Red Cross  
1 Copy - Desk File  
1 Copy - Health Record

ENLISTED PERSONNEL (Bureau of Medicine and Surgery Approvals)

1. Navy:

a. To "Retain for Further Treatment":

Endorsement: "1. Bureau of Medicine and Surgery, Washington, D. C."

Distribution: Original & 3 Copies - Bureau of Medicine and Surgery

1 Copy - Ward  
1 Copy - Red Cross  
1 Copy - Central Files  
1 Copy - Desk File  
1 Copy - Health Record

b. To "Full Duty, Fleet Reserve, Disciplinary Action (More than 1 SCM), No Disease":

Endorsement: "1. Bureau of Medicine and Surgery, Washington, D. C."

Distribution: (Same as a.), except extra copy for Veterans Administration Desk.

2. Marines:

a. To "Further Treatment";

Endorsement: "1. Bureau of Medicine and Surgery, Washington, D. C."

Distribution: (Same as 1.a.)

b. To "Full Duty":

Endorsement: "1. Bureau of Medicine and Surgery, Washington, D. C."

Distribution: Original & 4 Copies - To Bureau of Medicine and Surgery

1 Copy - Transfer Desk  
1 Copy - Ward  
1 Copy - Red Cross  
1 Copy - Desk File  
1 Copy - Health Record  
1 Copy - Central Files

c. To "Marine Fleet Reserve, Disciplinary Action (More than 1 SCM), No Disease":

Endorsement: "1. Bureau of Medicine and Surgery, Washington, D. C."

1. This man was transferred to U.S.

Marine Corps Base \_\_\_\_\_ on \_\_\_\_\_  
Ref. MarCorps Bufiled Jt. Ltr. 1500-120  
DGK-112-dmaj dated 2-21-45."

Distribution: Original & 4 Copies - To Bureau of Medicine and Surgery

1 Copy - Transfer Desk (Sent immediately to facilitate transfer)  
1 Copy - Ward  
1 Copy - Red Cross  
1 Copy - Desk File  
1 Copy - Health Record  
1 Copy - Central Files

FORT WORTH DRAFT - (Instructions - BuPers-BuMed-ComMarCorps Jt.Ltr. 20 Feb. 1945)

Endorsement: "1. Approved  
2. Transferred to USPHS Hospital, Fort Worth, Texas,  
on \_\_\_\_\_, via NATS."

Reference: BuMed C/L 46-149.

Distribution: Original & 1 Copy - Bureau of Medicine and Surgery  
1 Copy - Central Files  
1 Copy - Desk File  
1 Copy - Red Cross  
1 Copy - Ward  
2 Copies - Transfer Desk (Sent with patient to hospital).



PROPOSED MEDICAL HISTORY WRITE-UP DESK PROCEDURE

1. Health Record custody desk forwards Clinical Chart and Health Record to write-up desk. Thorough check for completeness of documents is made in presence of ward corpsman who delivers all papers.
2. Write-up clerk prepares abstracts from clinical records on NAVMED-H-8 of all transfers, discharges, separations, releases to inactive duty, etc., of both officers and enlisted personnel, Navy and Marine.
  - a. Ward medical officer writes all clinical notes on treatment of patient, also all surgical notes, laboratory examinations, treatment, and changes of diagnosis. Posts diagnoses and all changes, together with number of sick days. Obtains signatures on all forms.
3. Clerk completes NAVMED-H-5, Abstract of Service; name of hospital, date admitted, and date discharged is on face of form. On reverse side is indicated "take-up" information with diagnosis, disposition date and number of sick days.
4. Completes NAVMED-H-2, "Termination of Health Record" portion, if and when necessary.
5. Prepares misconduct reports, NAVS&A-519, after F card desk prepares misconduct "take-up" on either officers or EM:
  - a. States on report whether loss of time only, or loss of time and pay is involved. Assigns "CO" number to each report, and makes entry in misconduct log:

No.	Name	Ser./File	Type of Misc.	From	To	Rate	Days
-----	------	-----------	---------------	------	----	------	------
  - b. Prepares NAVS&A-519 on alcoholism cases, injuries from fights cases, venereal disease (if concealed) cases, and use of drug cases. Distribution of form: Copy #1 to Service Record, #2 and #3 to disbursing officer, and #4 to central files.
6. Expedites form NAVMED-Y, Physical Examination, in cases where this form is necessary.
7. Forwards Health Records to activities concerned.

## PROPOSED SUPERNUMERARIES DESK PROCEDURE

### ADMISSIONS

1. Supernumeraries desk clerk receives #5 copy of Admission Card at 0800 daily from admission unit; accompanied by any official documents pertaining to hospitalization, identification, etc., which have not been returned to supernumerary patient upon admission.
2. Checks #5 copy of Admission Card for inclusion of all pertinent information at time of completion of card. (On certain types of supernumeraries, i.e., civilian, humanitarian, indigent, etc., authority of the commanding officer should be received via the admission unit.)
3. Prepares desk file jacket on supernumerary patients for whom official documents have been received. Places all documents in jacket which is filed alphabetically, according to category of patient.
4. Form 10 desk forwards daily Form 10. Supernumerary clerk checks supernumerary admissions against admission cards received. "F" cards are received daily on supernumerary patients and are filed according to category.
5. Notifies duty stations of Army personnel and local U.S.P.H.S. on admission of supernumeraries.
6. Files #5 copy of Admission Card alphabetically, according to category of patient.

### DISCHARGES

1. Receives ward "duty slip" from particular ward that notifies desk that supernumerary patient is to be discharged. This form, delivered by supernumerary patient, is accompanied by the #1 copy of Admission Card (for check-out) and the Clinical Chart.
2. Clerk checks ward "duty slip", #1 copy of Admission Card, and Clinical Chart for proper signatures releasing patient.
3. Sends patient on "check-out" for proper signatures on #1 copy of Admission Card. (To bag room, library, mail room, agent-cashier).
4. Returns all personal identification to patient from desk file jacket, upon patient's completion of "check-out".
5. Types main gate pass for patient, showing name, date of discharge, time, and whether or not patient will return for out-patient treatment.
6. Furnishes name of supernumerary discharges to Form 10 desk at 0800 daily on discharges up to 2400 previous day, as follows:

Name	Classif.	Jacket #	Date Adm.	Diagnosis (Final)	Disposition or Home Address	From Ward #
_____	_____	_____	_____	_____	_____	_____
7. Sends charts to central files after necessary histories are prepared. Certain supernumeraries report to agent-cashier for payment of hospitalization charges at time of admission.
8. Sends all official military orders, etc., to personnel officer for signature of XO in endorsement.
9. Notes #5 copy of Admission Card regarding disposition of patient, and other pertinent information. Additional information or corrections appearing on #5 copy are posted to #1 ward copy of Admission Card before patient's jacket is closed out. Files #5 copy, alphabetically, regardless of category, in "inactive" desk file.
10. Pulls "F" cards on discharged supernumeraries from "active" file, notes as to disposition, and sends to F card desk for continuation in F card procedure.



#### CHECKAGE OF SUBSISTENCE FOR RETIRED NAVY AND MARINE OFFICERS

1. Clerk completes NAVS&A-534, Hospital Ration Notice, on the date supernumerary is admitted for treatment. Prepares in triplicate for signature of records officer. Form shows name, rank and date admitted.
2. Prepares same form on discharge, identically as above, except inclusion of date of discharge.

Distribution: Original and #2 copy mailed to BuS&A, Master Accounts Division, Cleveland, Ohio (Navy personnel)

Original and #2 copy mailed to HQ, USMC, Paymaster's Dept., Marine Corps Allotment Office, Washington, D. C. (Marine personnel)

#3 copy is retained for central files (patient's jacket)

(Liaison is maintained with Form 36 desk on preparation of this form.)

#### REPORTS

1. Monthly: to Bureau of Medicine and Surgery, signed by C.O. (Original and 3 copies: original and 1 copy to BuM&S, 1 for desk file, and 1 copy for central files (patients' jackets)).

- a. Coast Guard Enlisted Personnel
- b. Coast Guard Retired Personnel
- c. Coast Guard Officer Personnel
- d. Foreign Navy
- e. Civil Service Employees of Government Establishments

This report includes name of patient hospitalized during month, diagnosis, from where admitted, diagnosis; date of admission, date of discharge, number of sick days. In addition, the report on ECC patients shows the occupation of the patient. In the computation of sick days, the day of admission is not counted, but the day of discharge is counted.

2. ECC Reports: (When appropriate) - (BuMed Manual and U.S. Employees' Compensation Commission Regulations for reference).
- a. CA-16 or CA-17 is authority for admission, showing the name of patient, place of employment, date and nature of injury, and signed by official superior of the employee. Note: One of these forms must be received at the time of admission or, in the case of emergency, within 48 hours.
  - b. CA-33 is authority for admission in case of hernia. (CA-17 is used in cases of doubtful injury, the medical officer in charge of the case determines as soon as possible the status of the case.) The official superior is notified of the medical officer's opinion, and in the event the injury is not occupational, the patient is discharged as an Employees' Compensation Commission patient.
  - c. CA-20 is initial medical report submitted immediately upon beginning of treatment. Prepared in triplicate, original to U.S. Employees' Compensation Commission, with original of CA-16 or CA-17; second copy to official superior of patient; third for patient's jacket (central files). Form is completed and sent to medical officer in charge of case for signature.
  - d. Supplementary reports are submitted to Commission in case of U.S. Employees' Compensation Commission patients remaining in hospital more than 30 days or in case of serious injury or occupational disease.

- e. CA-4 is initial claim for compensation on account of injury. Originates with employee 18 days after date pay stops and medical certificate is completed by doctor. CA-4 is prepared in same manner as the CA-20. CA-4 is forwarded to the employees' official superior for the final certificate.
  - f. CA-8 is submitted every two weeks employee is disabled. These are sent to U.S. Employees' Compensation Commission via employee's official superior. Details are obtained in preparation from the medical officer in charge of case.
  - g. CA-78 is a report of surgical operations which is forwarded to the U.S. Employees' Compensation Commission, reporting all operations requiring the use of local or general anesthetic.
  - h. CA-21 is a discharge report of injury case. It is forwarded to the U.S. Employees' Compensation Commission when U.S. Employees' Compensation Commission beneficiary is discharged from treatment. Accompanying this report, is a copy of patient's clinical record. (See item 7 under DISCHARGES).
  - i. An out-patient treatment card is furnished each employee returning for out-patient treatment. Card shows name, place of employment, nature of work, place of residence, time and place of accident or injury, history of accident or injury, time of applying for treatment, etc. Reverse side of card is used by medical officer in charge of case for record of treatment. Patient reports to supernumerary desk each time he applies for out-patient treatment. Form CA-20 is prepared on consultation cases.
3. Miscellaneous: (When appropriate) (Coast Guard Personnel, Merchant Seamen, Maritime Service Personnel.)
- a. Form 1971-F of the Federal Security Agency, U.S. Public Health Service. One of these forms must accompany the above type of admissions. If admitted in emergency without this form, local U. S. Public Health Service is contacted by telephone and the card requested. (On Coast Guard personnel) Records officer signs in triplicate, original is sent to U. S. Public Health Service, on admission, balance is retained until time of discharge when they are completed. Second copy is then sent to U. S. Public Health Service, and third is retained for patient's jacket (central files).
  - b. In case of Merchant Marine or Maritime Service personnel admitted without a 1971-F, an affidavit is furnished them showing their name, vessel to which attached and length of service. A Red Cross representative notarizes the statement, which is then forwarded to U. S. Public Health Service for request on the 1971-F.
  - c. Form NCG-2522 is prepared in triplicate upon admission of Coast Guard personnel. Two copies are sent to duty station of personnel, third is retained for desk file. Upon discharge a final medical certificate is prepared and distributed in the same manner. No. 3 copies of admission data and discharge data are then forwarded to central files for inclusion in patient's jacket.

#### ACTIVE ARMY PERSONNEL

Army personnel are admitted to naval hospitals at the request of their commanding officer or their own request. In case of an emergency admission the duty command is notified by letter or dispatch giving name, rate, date of admission and diagnosis. The nearest Army hospital is also furnished a copy of this letter or dispatch. Upon discharge from treatment, arrangements are made with the nearest Army installation for return of the patient to duty. He is furnished orders and a copy of his clinical chart is sent to the nearest Army hospital.

Army officers and nurses are admitted and discharged in the same manner. They are charged for subsistence and are directed to check-out with the agent cashier at the time of discharge.



#### FOREIGN SERVICE PERSONNEL

Personnel are admitted upon request of the commanding officer or consular representative. Arrangements are made with the nearest consular representative for their return to their ships or country upon their discharge from treatment. Patient is furnished orders and a transcript of his clinical record. The original letter requesting treatment is forwarded to the Bureau of Medicine and Surgery with the first monthly report showing hospitalization.

#### NAVMED "U" (Report of civilian treatment for Navy and Marine Personnel)

This form is submitted on each patient admitted from a hospital other than military and for ambulance service furnished on which there is a charge. (This information is on the Admission Card.) The form is prepared in triplicate for signature of executive officer, forwarded to the Bureau of Medicine and Surgery in duplicate with all statements or bills from whomever furnished treatment or supplies, and a signed statement from the patient certifying that he received services. Payee also certifies on the face of the bill or statement that it is correct and just "and payment has not been received". The original bill is signed by the payee. The third copy is filed in the form "U" desk file.

#### MEDICAL HISTORIES

On all supernumerary patients discharged, a medical record is typed in narrative form or on the NAVMED-H-8, Medical History, and sent to the agency concerned. (See item 7 of DISCHARGES.)

## PROPOSED VETERANS ADMINISTRATION DESK PROCEDURE

### ADMISSIONS

1. Admission Unit forwards #5 copy of Admission Card at 0800 daily, accompanied by all official documents pertaining to hospitalization of Veteran patients. (P-10 on emergencies, or VA-7522, Authorization for Furnishing Medical or Dental Service, or VA-2557, Admission Card.)
2. Veterans Administration desk clerk prepares a form VA-2593, Record of Hospitalization or Domiciliary Care, on all admissions: white copy Veterans Administration Headquarters, Washington, D. C.; pink copy to Veterans Administration regional office; and green copy to desk file. (authorization and C# are entered on card if authority is received.)
3. Enters additional information on #5 copy of Admission Card such as World War I or World War II, SC or NSC (service-connected, or non-service-connected), also "C#".
4. Form 10 desk forwards Form 10 each morning. Veterans Administration desk clerk checks #5 copy of Admission Card against Form 10 for completeness, total admissions, etc.
5. Prepares envelope for desk file use as follows:

Jacket # _____	Jacket # _____
Name _____	Diagnosis and Diagnosis # _____
Classification _____	
Date Admitted _____	
Date Discharged _____	

Inserts all official papers received in envelope. Files envelope in drawer, alphabetically.

6. Enters "C#" on #5 copy of Admission Card and green copy of VA-2593. If authorizations, VA-7522 or VA-2557 are received while patient is hospitalized, authorization is inserted in envelope.
7. Files #5 copy of Admission Card alphabetically in active file.
8. Sends day's admissions, VA-2593 forms, to records officer for signature and mailing at close of day.

### DISCHARGES

1. Patient reports to Veterans Administration desk with patient's disposition slip, Clinical Chart, and #1 copy of Admission Card (ward copy).
2. Veterans Administration desk clerk pulls #5 copy of Admission Card from active file.
3. Pulls envelope from active jacket file at desk.
4. Enters disposition, date, and authority on #5 copy of Admission Card.
5. Enters pencil notations on green copy of VA-2593, as to operation data, disposition as to AMA (against medical advice), AOL, AWOL, transfer, death, etc.; also date.
6. Instructs Veteran patient to check-out, using #1 copy of Admission Card. Upon completion of check-out, gate pass is issued patient.
7. Prepares form VA-2593 on all discharges. (Distribution is same as for admissions.) In addition to admission information re-typed from green file copy in envelope, "C#" must be entered if authorization is received in interim, and disposition data entered from information on green file copy.



8. Optional:

a. Removes pertinent clinical forms necessary for possible claim requests from Clinical Charts, and sends to photostat unit for reproduction - 2 copies. This procedure is optional, depending upon particular hospital, veteran patient load, and requests for copies of clinical records.

b. Prepares memo for photostat unit with information as follows:  
Name                      Jacket #                      Number of documents to be photostated.  
(Copy of memo is retained in desk file to check off photostats received.)

c. Sends photostats to regional office. Refiles other documents in envelope.

9. Sends day's discharges (VA-2593) to records office for signature.

10. Inserts green copy of Veterans Administration discharges in envelope.

11. Prepares daily memo for Form 10 desk regarding Veterans Administration patients discharged, as follows:

<u>Name</u>	<u>Classif.</u>	<u>Jacket #</u>	<u>Date Adm.</u>	<u>Diagnosis (Final)</u>	<u>Disposition</u> <u>or Home</u> <u>Address</u>	<u>From</u> <u>Ward</u> <u>No.</u>
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12. Sends veteran patient envelope (jacket) to central files.

13. Segregates #5 copies of Admission Cards (on discharges) until following day when Form 10 is received, then checks #5 copies against Veterans Administration patient discharges.

14. Files #5 copy of Admission Card, alphabetically, in inactive file.

REPORTS

1. VA-2601, Monthly Report of Veterans Administration Hospitalization and Domiciliary Care.

2. VA-6645, Annual List of Veterans Receiving Institutional Care.

3. All local reports required by commanding officer or Veterans Administration regional or branch offices.

PENSION CLAIMS

1. During hospitalization of patient, and upon being notified that he is to be surveyed, patient obtains assistance from Red Cross in filing VA-526, Veterans' Application for Pension or Compensation for Disability Resulting from Active Military or Naval Service. Red Cross clerk completes claims and forwards to Veterans Administration local representative.

2. Clerk files list of claims and receives copies of VA-526 from Veterans Administration representative at the beginning of each month, showing approximate date of discharge of patient. Receives copy of NAVPERS-553, and a copy of NAVMED-M.

3. Requests Health Record or NAVMED-Y, Report of Physical Examination, from Health Record custody desk on patients who have filed claim.

4. Forwards Health Record (on medical surveys) and "Form Y" (on expiration of enlistment or convenience of Government discharges), to photostat unit for reproduction, with memorandum. (One copy retained at desk.)

5. Upon receipt of photostats, sends forms VA-526, NAVPERS-553, NAVMED-M, and photostats of Health Records (NAVMED-H-8) or Form "Y" to Veterans Administration regional office nearest patient's home. Prepares letter of transmittal for forwarding documents. (NAVMED-M only forwarded on medical surveys.)

6. Notes #5 copy of Admission Card (filed at transfer desk) with information showing location of regional office which received claim data.
7. Returns Health Record and form "Y" to Health Record custody desk.



PROPOSED ENLISTED PATIENT RECEIPT DESK PROCEDURE (NAVY & MARINE)

1. Admission unit forwards #5 copy of Admission Card and all accompanying documents, except Health Record, at 0800.
  - a. Receipt clerk receives all documents (incoming mail) which were previously requested, with letters of transmittal. Enters date of receipt on #5 copy of Admission Card. If Form "G" is received, it is sent to bag room.
  - b. Requests, by letter or dispatch, documents on patients who were admitted without them and which have not been noted on Admission Card as being previously requested by the admission unit. (Sends original to previous duty station, and places duplicate in desk file.)
  - c. Upon admission of a patient who is on terminal leave, clerk immediately sends speed-letter or despatch to stop terminal leave to place of separation, Bureau of Medicine and Surgery, Bureau of Naval Personnel, and retains copy in local file. Patient is subsequently re-processed for separation when treatment is completed.
2. Checks #5 copy of Admission Card for completeness. For example, has command been notified of emergency admission of service patient? Have any papers regarding pending disciplinary action been received?
3. Acknowledges receipt, and returns letter of transmittal covering records.
4. Prepares tally file card (receipt) on each Service Record. Transfers #3 copy of form NAVPERS-500, if received, from the Service Record, to the personnel accounting desk, and notes the action on the tally card. Personnel accounting clerk returns #3 copy of NAVPERS-500 to receipt desk after checking it against #7 copy of the Admission Card.
5. Makes pay account entries, including name of hospital and date of admission of patient. Prepares memorandum for disbursing office in duplicate, listing names, with serial number and rate, on pay accounts received. Original memorandum, bearing notation of receipt of material is returned by disbursing office and filed.
6. Forwards Personnel Qualification Card, NAVPERS-609 (from service record) to education office together with 2 copies of covering memorandum. Original memorandum bearing notation of receipt of material, is returned by education office and filed.
7. Completes "Ultimate Destination" part of Service Record, page 9-Y, showing name of hospital, time and date of reporting, and name and rank of records officer for his signature. Original is filed in Service Record and duplicate is sent to the Bureau of Naval Personnel.
8. Endorses Standard Transfer Orders, NAVPERS-562/NAVS&A-536. One copy is signed and returned to originating activity, one copy is retained in the patient's Service Record, and one copy is sent to central files for the patient's jacket.
9. Files Service Records and tally (receipt) cards alphabetically, and separately for Navy and Marine categories. Whenever the Service Record is requested for official use, tally card is signed by authorized persons as a receipt.
10. Prepares requests for records in duplicate. Sends original to activity, and files copy chronologically for follow-up. Makes proper notation on copy of Admission Card at time of request and upon receipt of records. When records are received, destroys copy of request.
11. Form 10 desk forwards Form 10 to receipt desk each morning. Receipt clerk checks against #5 copies of admission cards to ascertain if all admission cards are received.
12. Files #5 copy of Admission Card alphabetically, and separately for Navy and Marine categories. Notes patients returning from convalescent leave, since additional procedures must be followed for this group.



13. Receives leave papers (emergency) from leave desk and notes time of return of papers. Completes NAVS&A-518, page 9-U, for leave rations (based on data in leave papers). Assigns commanding officer's number on form in numerical sequence, and records hour of departure, date and hour of return, AOL or AWOL information, if any. Distribution is shown on form. Makes appropriate entry on page 5 of Service Record and inserts leave papers therein.
14. Prepares NAVS&A-515, page 9-X, when necessary. (Disbursing office usually notifies patient, or this desk, as to amount of longevity due.) Standard distribution.
15. Completes Sea and FSD certificates.
16. Completes MAQ and beneficiary forms, when necessary. (NAVPERs-601-7.)
17. Prepares Family Allowance, NAVPERs-668 and beneficiary forms (NAVPERs-601-7).
18. Prepares per diem claims for air travel of patients, attendants, etc.
19. Prepares Dependents Identification Card, NAVMED-562, and local commissary card, when necessary.
20. Expedites sworn statement of pay account when necessary, and forwards five copies to disbursing office.
21. Receives and logs disciplinary action letters (see paragraph 1-a and 1-b) for purposes of checking subsequently for completion of disciplinary action. Letters are then forwarded to security officer for action. Stamps Admission Card, "Prisoner".
22. Prepares Declaration and Reward of Straggler, NAVPERs-640, on AOL patients who are absent 24 hours.
23. Prepares Report of Return of Stragglers, NAVPERs-641, on absentees (AOL) who return after having been absent either from the command or from other commands.
24. Prepares deserter papers, if AOL for 30 days.
25. If patient who is absent surrenders, or is apprehended at another naval activity, the following procedure is utilized:
  - a. Notifies man's ward to close out his chart.
  - b. Prepares page 9-Y of Service Record showing man's transfer to other activity as of the date he was received at that command.
  - c. Prepares baggage letter to have patient's personal effects shipped, subject to checkage of pay account.
  - d. Closes out all records - Health Record, Service Record, and pay account - and forwards under letter of transmittal to activity where patient is held.
26. Prepares page 9-Y for Service Record, in event of such disciplinary action as (a) captain's mast; (b) mitigations by Bureau of Naval Personnel, Judge Advocate General, commandant of naval district, and commanding officer; and (c) other cases as indicated.
27. Prepares commanding officer's orders to disbursing officer for adjustment of pay records, as indicated:
  - a. Release of GCM prisoner at expiration of his sentence of confinement.
  - b. Removal of mark of desertion when a prisoner is tried by GCM or SCM for absence rather than for desertion.



c. Order to rate or disrate, change status or classification for pay purposes or record purposes.

d. Order to check pay for unauthorized absence.

Daily Reports

1. Prisoner report, by category of prisoners.
2. Report of General Court Martial prisoners.
3. Report of captain's mast.
4. Absentee report, AOL and AWOL.
5. MAA prisoner's-at-large restrictions.
6. NAVPERS-3003, Weekly Report of Prisoners Confined.
7. NAVPERS-643, Semi-monthly Report of Prisoners.
8. Monthly report of summary court martial cases published.
9. Monthly report of prisoners in confinement in excess of 30 days other than for court martial reasons.

PROPOSED ENLISTED PATIENT TRANSFER DESK PROCEDURE (NAVY & MARINE)

TRANSFER TO DUTY

1. Ward forwards patient's "disposition slip," signed by ward medical officer, after patient has been notified that he is to be discharged to duty in 24 to 48 hours. This slip and patient's clinical chart are delivered to records office by ward corpsman before 1000, one or two days prior to duty party day. Clinical Chart must be complete.
  - a. Transfer clerk checks Clinical Chart and duty slip so that disposition dates agree.
  - b. Forwards Clinical Chart to Health Record custody desk for completion of Health Record.
2. Pulls #5 copy of Admission Card from active file.
3. Pulls Service Record from active file. Checks receipt (talley) cards for return of all forms used at other desks.
4. Contacts Marine detachment at hospital to ascertain disposition (next activity) of Marine patients. (Disposition depends on local or district instructions.) If patient's enlistment is to expire shortly, transfer desk is notified by patient discharge desk. Discharge procedures are followed.
5. Prepares rough duty list memorandum of duty party, and distributes copies to Health Record Custody Desk, Form 10 Desk, Post Office, Red Cross, Security Officer, garage, bag room, Information Desk, O.O.D., Marine detachment, and each ward with departing patients.

<u>Name</u>	<u>Rate</u>	<u>Serial No.</u>	<u>Br. of Serv.</u>	<u>Diagnosis</u>	<u>Disposition</u>
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6. Types disposition, date of disposition, and authority on #5 copy of Admission Card in appropriate spaces.
7. Prepares Standard Transfer Order, NAVPERS-563/NAVS&A Form 536, in serial number sequence for individual or for draft of personnel, depending on destinations.

Distribution: Original - To patient, or senior petty officer of draft.

#2 copy - To Service Record.

#3 copy - To command or activity to which patient is being transferred.

#4 copy - To disbursing office (for transportation and closing of pay account).

#5 copy - To district commandant's office.

#6 copy - To central files (patient's jacket).

#7 copy - For desk file.

- a. If Marine detachment prepares orders for marine personnel, clerk prepares a letter of transmittal for next station covering transfer of Health Record.

Distribution: Original &

#2 copy - To next activity (original to be receipted and returned).

#3 copy - For desk file (held until return of receipted original and then destroyed).

8. Types page 601-9Y of Service Record ("Ultimate Destination & Duty" part). Places all copies in Service Record.
9. Prepares NAVS&A-519, Misconduct Report, for patients who have been under a misconduct status. Types four copies: original to Service Record, #2 and #3 copies to disbursing office, and #4 copy to central files to be placed in patient's jacket.



10. Checks desk log on disciplinary action letters for completeness of such action. Calls security officer for final information. Prepares disciplinary action letter for next station. (Patients in disciplinary action status for having been AOL, AWOL for less than 30 days are transferred under "technical arrest".)
11. Prepares prisoner's orders in name of guard who is to accompany prisoner to duty station. Original and #2 copy to Marine guard, #3 copy to ward (to release patient).
12. Receives completed Health Record, including write-ups of medical histories and all endorsements and signatures, from Health Record custody desk.
13. Stencils smooth duty party list, after all duty party patients are cleared for discharge. (Distribution same as that for rough duty list.) Name, rate, service number, branch of service, jacket number, date of admission, diagnosis (final), disposition, and ward number of each patient are specified on smooth duty party list.
14. Prepares NAVPERS-693, Change of Address, for all patients being discharged.
15. Enters disposition date and authorization on #5 copy of Admission Card and sends it to personnel accounting clerk. When personnel accounting clerk finishes with card, he returns it to Enlisted Patient Transfer Desk for filing.
16. Files ward duty "Patient Disposition" slips.
17. On day of departure, ward nurse or medical officer notifies patient of departure. No. 1 copy of Admission Card (ward copy) is handed patient, who reports to transfer desk for instructions as to checking-out.

#### TRANSFERS TO OTHER NAVAL HOSPITALS

1. Transfer clerk sends speedletter or dispatch request to Chief of Naval Personnel via Bureau of Medicine and Surgery for transfer of patient to another hospital.
2. Notifies ward upon receipt of approved request. Ward corpsman prepares patient's disposition slip showing disposition to other hospital, and delivers to transfer desk with closed-out clinical chart. Sends clinical chart to Health Record custody desk for completion of Health Record.
3. Pulls #5 copy of Admission Card from active file.
4. Pulls Service Record from active file.
5. Notes information on rough duty list memorandum.
6. Types disposition, date of disposition, and authority on #5 copy of Admission Card.
7. Prepares Standard Transfer Orders (same procedure as for duty party patients).
8. Prepares page 601-9Y for Service Record.
9. Prepares NAVS&A-519, Misconduct Report, for patient who has been in misconduct status.
10. Checks disciplinary action (same procedure as under "Transfers to Duty" section). Prepares letter for next station.
11. Prepares orders for guard or attendant to accompany prisoner to duty station.
12. Receives completed Health Record from Health Record custody desk.
13. Completes NAVPERS-601-5A for conduct marks of patient.
14. Prepares letter to original command regarding disposition of patient.



15. Prepares NAVPERS-693, Change of Address, in three copies: Copy #1 to next of kin, #2 to post office, and #3 to other hospital.
16. Enters disposition date, and authorization on #5 copy of Admission Card, then sends to personnel accounting clerk.
17. Files patient disposition (ward duty) slips.
18. Notifies medical officer or attendant on day of departure of patient.

#### TRANSFERS TO FLEET RESERVE

1. Transfer Clerk types applications (NAVPERS-630) for transfers to Fleet Reserve (at end of 20 years' enlisted service).
2. Upon receipt of approved application, takes following steps:
  - a. Prepares new Service Record.
  - b. Closes out old Service Record and mails to Bureau of Naval Personnel.
  - c. Closes out copy #5 of Admission Card in active file.
  - d. Endorses authorization for transfer to Fleet Reserve (NAVPERS-631).
  - e. Makes entry on Continuous Service Certificate.
  - f. Completes Fleet Reserve Certificate.
  - g. Notifies ward and Health Record custody desk of entries to be made in Health Record.
  - h. Makes entries on page 9Y of Service Record.
  - i. Types orders for transferee.
3. Placement on the retired list of the Navy (originally Fleet Reserve personnel who have been on active duty and are placed on retired list at the end of 30 years in accordance with orders from the Bureau of Medicine and Surgery):
  - a. Makes entry on page 9Y of Service Record.
  - b. Closes out old card and prepares new card (#5 copy of Admission Card).
  - c. Notifies ward and Health Record custody desk of entries to be made in Health Record.
  - d. Makes entry in Continuous Service Certificate.
  - e. Types orders for transferee.
4. Release from active duty:
  - a. Makes entry on page 9Y of Service Record.
  - b. Notifies ward and Health Record custody desk of entries to be made in Health Record.
  - c. Closes out #5 copy of Admission Card.
  - d. Makes entry in Continuous Service Certificate.
  - e. Prepares page 11 for Service Record.
  - f. Types orders for transferees.
5. Computation of settlement of unused leave:
  - a. Computes terminal leave.
  - b. Prepares page 9Y of Service Record showing all leave taken and accrued since September, 1939.
  - c. Prepares claim for settlement of unused leave (Navy).
6. Forwards Service Record to Bureau of Naval Personnel and commandants of home naval districts of personnel.
7. Closes out and forwards, in all cases, #5 copy of Admission Card to personnel accounting clerk for daily diary information, after which it is returned to this desk for file.



#### SPECIAL ORDER TRANSFERS

For special order transfers, Bureau orders are received or district medical officers are contacted for instructions and authority. Otherwise procedure is identical with above.

#### SURVEYS OR DISCHARGES

1. Transfer clerk receives approved local or Bureau survey from survey desk.
2. Notifies ward of approval of survey.
3. Ward completes Clinical Chart, and sends with patient's disposition slip to transfer desk.
4. Transfer desk forwards Clinical Chart to Health Record custody desk for completion of Health Record.
5. Transfer desk forwards disposition slip and signed copies of survey to discharge desk.

# PROPOSED DISCHARGE DESK PROCEDURE

1. Discharge clerk receives signed copy of approved NAVMED-M survey forms and patient's disposition slip from transfer desk. On admission from terminal leave the patient's disposition slip is received from the transfer desk for discharge. On enlisted expirations, the disposition slip is received from the transfer desk. On transfers to a Veterans Administration facility, a VA Washington letter is received, designating the facility and a NAVMED-M, and patient disposition slip are also received.
2. Pulls patient's Service Record from files.
3. Pulls #5 copy of Admission Card, and all speedletters and despatches relative to patient's admission from terminal leave.
4. Receives Notice of Separation, NAVPERS-553, which was prepared in the civilian readjustment office immediately after survey board concluded hearing and advised patient of recommendation for survey. Notifies Red Cross of patient's transfer to Veterans Administration facility. Arranges interviews with Red Cross, who assist in the preparation of pension claim forms.
5. Completes all blanks in "Grade Sheet" (worksheet) from information in Service Record, survey form, and Notice of Separation.
6. Determines type of discharge, either on basis of marks, existing directives, or Bureau of Naval Personnel letter approving recommended discharge.
7. Completes discharge papers as follows: (On transfer to Veterans Administration facility, dates of discharge are left blank until veteran's facility notifies hospital regarding receipt of patient.)
  - a. Service Record, pages 9 and 10 (original and copy): discharge information, authority for discharge, mileage information, terminal leave information, professional qualifications, and conduct and marks.
  - b. Service Record, pages 11 and 12, "Orders to Close Account" (original and 3 copies).
  - c. Presidential testimonial.
  - d. NAVS&A-550, Mustering Out Pay (Original and 3 copies).
  - e. Statement of Claim for Settlement for Unused Leave (original and 4 copies).
  - f. Memorandum letter is sent to last duty station advising commanding officer that patient is being discharged by reason of medical survey, and hence will not return to duty station (original and one copy).
  - g. Letter is sent to next of kin, in case of minors, containing information that patient is being discharged and city and state to which transportation is being furnished.
  - h. Discharge certificate is prepared. Entry is made in log of serial number of honorable discharge certificate, as follows:

CO#	Enl. Date	Survey Date	Disch. Date	Name	Rate	Ser. #	Place of Enl.	Type Disch	Cert. #
  - i. Certificate of Satisfactory Service, NAVPERS-554.
  - j. Change of Address, NAVPERS-693.
  - k. Terminal leave orders (original and four copies).
8. Calls patient from ward and obtains his signature on NAVPERS-601, pages 9 and 10, bearing discharge certificate number; pages 9 and 10, stating number of terminal leave days granted; NAVS&A-550; NAVPERS-693; and NAVPERS-553 and 554. Fingerprints are taken on first and fifth copies of NAVPERS-553. Patient returns to ward.



9. Records officer signs all necessary forms.
10. Clerk enters disposition, date and authority of discharge, type of discharge, amount of leave accrued, home address, and line of duty ("Yes" or "No"), on Admission Card copy #5. Transportation and attendants are requested, if necessary.
11. Forwards following forms to disbursing office:
  - a. Three copies of NAVPERS-601, pages 11 and 12. (Two copies retained by disbursing office and original returned.)
  - b. Four copies of NAVS&A-550, Mustering Out Pay. (All copies retained by disbursing office.)
  - c. Discharge Certificate. (Returned to discharge desk.)
  - d. Service Record. (Not retained, returned from pay office.)
  - e. Four copies of NAVPERS-553, Notice of Separation. (All copies returned to discharge desk.)
  - f. Two copies of terminal leave orders. (Copy retained by disbursing office and original returned.)
  - g. Letter of gratuity for issue of set of clothes not to exceed \$30.00 in case of "unfit", "undesirable", or similar discharges. (Returned by disbursing office.)
12. Upon return of forms from disbursing office, clerk places original of pages 9, 10, 11, and 12, of NAVPERS-601, "BuPers" copy of NAVPERS-553, and a copy of terminal leave orders in Service Record.
13. Prepares stencil on discharges for following day as follows:

Name	Rate	Ser#	Ward#	Type of Discharge	Term Leave Exp. Date	B of S	Jacket#	Date Adm.	Final Diagnosis

This stencil is mimeographed with sufficient copies to include all departments and wards, as well as the civil readjustment office, Red Cross; and all desks in the records office which require this information. (These desks are the Form 10, Medical Survey, Veterans Administration, Civil Readjustment, Red Cross, F-Card, Transfer, Personnel Accounting, Form 36, Health Record Custody, and Pay Office.)

14. Prepares official records envelope with name, date of departure on terminal leave, and terminal leave expiration date, and inserts the following documents therein:
  - a. President's testimonial
  - b. Discharge certificate
  - c. Notice of Separation (original and last copy)
  - d. Statement of Service
  - e. NAVMED-M (original and one copy or, if Bureau approved survey, original only)
  - f. Grade Sheet
  - g. Service Record
  - h. Copy of Orders (original)
  - i. Next of kin letter
  - j. Last duty station letter

When patient departs, next of kin letter and last duty station letter are mailed immediately.

15. Files official envelope, chronologically, until expiration of terminal leave.
16. On day of departure, patient checks out with #1 copy of Admission Card. Clerk issues copies of terminal leave orders, NAVPERS-553 and NAVPERS-554. Sends #5 copy of Admission Card showing disposition, date, etc., to personnel accounting clerk, who returns it to this desk for filing.

17. Veterans Administration facility notifies hospital regarding receipt of patients. Forwards original and one copy of official discharge records to patient, one copy to central files for patient's jacket, one copy to central correspondence files, and one copy to office file.
18. After Patient's departure, the following is accomplished:
  - a. Forwards claim for unused leave to Bureau of Naval Personnel.
  - b. Forwards NAVPERS-693, Change of Address, to mail directory service.
  - c. Sends #1 copy of Admission Card (ward copy) with disposition, date, and authority added, to central files for patient's jacket.
19. Upon expiration of terminal leave of patient, clerk completes Health Record and Clinical Chart, which were received from the Health Record custody desk. Forwards Health Record to Bureau of Medicine and Surgery, Clinical Chart to central files, and closes out Service Record and sends it to Bureau of Naval Personnel with letter of transmittal.
20. On local survey, clerk sends original and one copy of NAVMED-M to central files; Bureau survey, clerk sends original to central files. Sends copy of terminal leave orders to central files.
21. Pulls "official record" envelope and forwards it to discharged patient.
22. Prepares form "Y" for expiration of enlistment and all discharges, other than medical survey, including patients reporting in from terminal leave.
23. If patient is ready for discharge and goes AWOL, station receiving him notifies hospital, whereupon all papers are sent to the new station, which returns the necessary copies.



## PROPOSED OFFICER PATIENT DESK PROCEDURE

### ADMISSION

1. Admission unit forwards #5 copy of Admission Cards each morning at 0800.
  - a. Officer patient or corpsman, at officer's request, delivers all official records to officer patient desk.
  - b. In emergency cases, officer patient clerk requests official records from duty station by telephone, speedletter, or dispatch. Notes data requested on #5 copy of Admission Card.
  - c. On terminal leave admission cases, receives separation orders and Notice of Separation, NAVPERS-553, from separation activity. Prepares despatch, giving date of admission, diagnosis, and probable duration of hospitalization, in accordance with AISTACON dated 25 September 1946. Sends original to Bureau of Naval Personnel or Marine Corps, copy to Bureau of Medicine and Surgery, copy to Bureau of Supplies and Accounts, field Accounts, Cleveland, and copy to separation center. Requests Health Record from district commandant of the patient's home district.
2. Endorses orders on each officer, Navy and Marine. Sends to commanding officer for signature. Upon return, files in manila envelope prepared with name and rank of each officer patient and date admitted.
3. Enters date of admission on pay account. Forwards pay account to disbursing office, after making notation on #5 copy of Admission Card.
4. Types NAVMED-HF-1, Admission or Discharge of Officer. Distributes according to instructions on form. Extra copy is for officer patient's file. (The estimated length of hospitalization information is obtained from the Admission Card.)
5. Inserts all patient's official documents in desk file envelope. Files envelopes alphabetically.
6. Prepares NAVS&A-534, Hospital Ration Notice, for all officers admitted. (As permits to "subsist out" are received, additional NAVS&A-534 forms are prepared. When patient returns to "subsist in" NAVS&A-534's are again prepared.)
7. Receives Form 10 daily. Checks #5 copy of Admission Cards against officer patient admissions, then files alphabetically in active file.

### DISCHARGE

1. Receives officer patient's disposition slip each morning from SOQ, showing patients to be discharged two days later. SOQ medical officer forwards Health Record and Clinical Charts to this desk.
2. Sends Health Record and Clinical Chart to Health Record custody desk clerk, who records receipt of Health Record on tally card, and forwards Health Record and Chart to Health Record write-up desk for completion.
3. Pulls officer patient's desk file envelope. Removes orders, Service Record, Continuous-Service Certificate, Officers Qualification Jacket (NAVPERS-305) and Form "G". Pulls #5 copy of Admission Card from file. Posts disposition, date, and authority, and sends it to personnel accounting desk for daily diary information. Files card in closed file upon its return from personnel accounting desk.
4. Endorses orders, and sends to commanding officer for signature. Cuts stencil on orders for officers to be separated.

5. Prepares following forms, as necessary, depending on type of discharge or type of orders:
  - a. Hospital Ration Notice, NAVS&A-534, for officers being discharged, after all ration notices for admission, subsisting in, and subsisting out have been checked.
  - b. Admission or Discharge of Officer (if hospitalized over 7 days), NAVMED-HF-1.
  - c. Officer's Fitness Report, NAVPERS-310.
  - d. NAVPERS-601, pages 9 and 10, 11 and 12, (For Service Record and Continuous-Service Certificate in case of officer having previous enlisted status.)
  - e. Change of Address, NAVPERS-693. (Authorization BuPers Circular Letter 239-45.)
  - f. Mustering Out Pay, NAVS&A-550.
  - g. Certificate of Assignment of Quarters or Termination thereof, NAVS&A-532. (Authorization S&A Manual, Vol. 5, Article 54103)
  - h. Notice of Separation from Service, NAVPERS-553.
  - i. Certificate of Satisfactory Service, NAVPERS-554.
  - j. Presidential Testimonial.
  - k. USNR Identification Card, NAVPERS-904.
  - l. USN Retired Identification Card, NAVPERS-907.
  - m. Report of Leave of Absence, NAVPERS-321.
  - n. Misconduct Report, NAVS&A-519.
  - o. Reimbursement for Lost Clothing, NAVPERS-324.
  - p. Officers' Leave Record, NAVPERS-329.
  - q. Quarters Assignment (for Marine officers), NMC-729 pm.
  - r. Uniform Gratuity (initial, subsequent, or 4-year payment - Authorization is ALNAV 14-45), NAVS&A-445A.
  - s. Report of Address, NAVPERS-322.
  - t. Next Duty Detail, NAVPERS-340.
6. Prepares following memoranda, as necessary, depending on type of orders:
  - a. Flight Certificate (aviation pay). (Authorization: S&A Manual Art. 2140.)
  - b. Temporary Appointment & Promotion. (Authorization specific promotion ALNAV.)
  - c. Sworn Statements of loss of pay accounts.
  - d. Officers' Longevity.
  - e. Statement of Service. (Authorization: ALNAV 200.)
  - f. Reimbursement claims for household effects, clothing and transportation of dependents, and mileage claims.



7. Officer patient also accomplishes following procedure, as necessary, depending on type of orders or discharge:
  - a. Physical Examination, NAVMED-Y, is prepared in case of discharge following admission during terminal leave.
  - b. Contacts Veterans Administration representative for interview regarding claim for compensation
  - c. Visits civil readjustment officer (all discharges).
  - d. Arranges with Fleet Reserve section for transfer to Fleet Reserve.
  - e. If patient is to be transferred to another hospital, clerk prepares NAVMED-G, Hospital Ticket.
8. Health Record, Pay Account, Service Record, Continuous-Service Certificate, and Officer's Qualification Jacket are given to officer, also Form "G", when necessary.
9. Patient checks out with officer of the day, and picks up orders at executive officer's office.
10. Officer patient clerk prepares memo of officer patients discharged for Form 10 desk each morning. Headings of columns on memo are as follows:
 

Name	Rank	File#	Branch of Service	Jacket No.	Date Adm.	Diagnosis (Final)	Disposition	Term Lv. Expir. Date	Ward #
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
11. Notes on #5 copy of Admission Card disposition, date and authority for discharge. Files alphabetically in "inactive" file.

#### REPORTS

Reports on Roster Report of the Medical Corps, NAVMED-953, (semi-monthly), medical officers (not dental officers) received as patients, showing name, rank, corps, classification, etc. This report is prepared separate from that on staff medical officers.

## PROPOSED DEATH DESK PROCEDURE

### NAVY AND MARINE PERSONNEL

1. Ward medical officer notifies officer of the day regarding death of a patient.
2. Ward medical officer notifies next of kin, if present.
3. Officer of the day notifies death desk.
4. Records office calls ward for #1 copy of Admission Card, on which have been noted time and cause of death. Information is later corroborated by death report prepared by ward medical officer.
5. Death clerk obtains next of kin information from Admission Card.
6. Notifies next of kin by priority despatch if not present. Copy of outgoing message is returned to death desk via records office.
  - a. Prepares NAVMED-HF-61, Information for Next of Kin, for Navy personnel and NMC-817-QM for Marine personnel, and mails to next of kin. (Death desk clerk gives form to next of kin if latter is present.)
  - b. Sends despatch to next of kin for the various categories of patients in accordance with paragraph 3417, Manual of the Medical Department.
7. Notifies disbursing office of death, obtains information regarding rate of pay, insurance, allotments, etc., from this office.
8. Notifies SECNAV of death by priority despatch in accordance with Art. 1513 of Navy Regulations and paragraph 341, Manual of the Medical Department.
9. Notifies last duty station of deceased by information copy of despatch.
10. Master-at-arms inventories personal effects on ward of veteran and service patients. Bag room personnel inventory gear in bag room. Signed inventories for Navy personnel are given to death desk, and inventories for Marine personnel are forwarded to nearest Marine activity.
11. Clerk notifies contract mortician. Prepares NAVMED-HF-23 for mortician's purchase order of items furnished: embalming, washing, delivery of remains to shipping point, health department permits, and transportation to funeral home.
12. Morgue watch prepares required number of copies of Certificate of Death, NAVMED-N, with fingerprints of deceased.
13. Ward medical officer prepares "rough" copies of State death certificate.
14. Ward medical officer prepares and signs "rough" NAVMED-N giving details of death. Form is approved by chief of service and commanding officer.
15. Death desk clerk types "smooth" State death certificate for signature of ward medical officer. Original and one copy are retained in file. (If accident or coroner case, additional copy is prepared for mortician.)
16. Requests next of kin to send written or telegraphic instructions concerning place of burial. Contract mortician is notified. If burial is in a national cemetery, superintendent is notified by despatch, and the remains are consigned direct. Commandant of naval district is notified by information copy, so he will provide funeral honors.



17. Prepares NAVMED-R on casket and ensign which are furnished. Sends casket, ensign, for burial to mortician. (If uniform is necessary, it is requested from small stores on memorandum.)
18. Officer of the day inspects body before it is embalmed and clothed, and before mortician claims body. Receipt for remains is claimed from mortician.
19. Clerk receives autopsy reports and includes facts on "rough" NAVMED-N.
20. Prepares "smooth" NAVMED-N on all deceased patients. Obtains signatures of ward medical officer, chief of service, and commanding officer. Sends four copies to Bureau of Medicine and Surgery for Navy and Marine patients, one copy for dependents, and two copies for supernumeraries; and one copy to patient's jacket.
21. Officer of the day inspects body at funeral parlor of contract mortician.
22. Death clerk prepares bill of lading if shipment of body is to be sent by express. Sends original and copy to consignee of remains by special delivery.
23. Contacts personnel officer of nearest naval station for pallbearers and firing squad, if burial is local.
24. If escort accompanies remains, prepares orders for escort and requests two first-class train tickets for transportation. (This procedure does not apply to Marines.)
25. Forwards telegram to next of kin and consignee mortician regarding arrival of body and escort.
26. See paragraphs 3430 and 3453, Manual of the Medical Department, for burial at Arlington and burial of retired unclaimed personnel.
27. Sends letter of condolence to next of kin.
28. Makes entry in Burial Register, NAVMED-HF-38, and "Cemetery Records" (local form) if burial is local.
29. Sends letter to SecNav confirming despatch regarding death.
30. Requests Health Record and Clinical Chart from Health Record custody office and closes out. Sends Health Record to Bureau of Medicine and Surgery, and places Clinical Chart, with copy of NAVMED-N in patient's jacket in files.
31. Requests Service Record from transfer desk. Closes out face of Service Record and pages 9, 10, 11, and 12 of NAVPERS-601. Sends Service Record to Bureau of Naval Personnel.
32. F-card desk makes entry on "F" card. (Obtains information from Form 10.)
33. Clerk sends personal effects to Officer in Charge, Personal Effects Distribution Center, Naval Supply Depot, Clearfield, Utah.
34. Forwards all papers to central files for inclusion in patient's jacket.
35. Sends Continuous-Service Certificate, and personal papers of deceased to next of kin.
36. Prepares Report of Disposition and Expenditures--Remains of Dead, NAVMED-609, monthly, giving report of burial of deceased.

#### VETERANS ADMINISTRATION PATIENT PERSONNEL

1. Death desk clerk contacts Veterans Administration local representative immediately upon notification of death of veterans.

2. If next of kin is present, sends him to VA representative immediately.
3. VA representative advises next of kin about use of contract mortician, or next of kin states preference for mortician of own choice.
  - a. Sends next of kin to undertaker for arrangements.
  - b. Obtains direct written permission from next of kin to perform post-mortem.
4. If next of kin is not present, notifies him by despatch or Western Union message as follows:

"I deeply regret to inform you that your \_\_\_\_\_ a Veterans Administration patient died (date). Additional information will be sent to you by the Regional Manager, Veterans Administration, (city and state), with whom all arrangements for disposition of the body should be made. Sincerest sympathy is extended."
5. Advises Veterans Administration regional director through VA representative regarding disposition of remains of patient. Also forwards the following information:
  - a. Name of patient.
  - b. Date and time of death.
  - c. Diagnosis.
  - d. Place of residence.
  - e. Next of kin and address as given by patient upon admission.
  - f. Whether or not next of kin has been notified.
  - g. Whether or not next of kin (if present) granted permission for post-mortem examination.

(NOTE: If next of kin is not present, requests Veterans Administration to obtain permission for hospital to perform post-mortem examination.)
6. Prepares necessary copies of State death certificate and furnishes copies to Veterans Administration regional office, as required.
7. Inventories personal effects and delivers either to next of kin, if present, or to regional manager, on request of next of kin.
8. Issues flag, as directed by Veterans Administration.
9. Prepares NAVMED-N, as required, on all deceased patients and furnishes Veterans Administration regional office with the number of copies requested.
10. Officer of the day inspects body prior to transferring it to custody of representative of Veterans Administration regional director.



PROPOSED SERIOUS AND CRITICAL LIST PROCEDURE

1. Ward medical officer decides whether patient is to be placed on serious or critical list and when he is to be removed from either serious or critical list.
2. Nurse or senior corpsman completes memorandum (usually local form) placing the patient on or removing him from serious or critical list, and sends copies to officer of the day, executive officer, chief of service, and chaplain.
3. Clerk prepares priority despatch informing next of kin of patients on critical list. Despatch is cleared through officer of the day and is sent by communications officer.

Clerk prepares despatch or letter informing next of kin of patients on serious list. Despatch or letter is cleared through officer of the day and is sent by communications officer or personnel officer.

4. Types daily stencil of serious and critical list, which contains following information:

- a. Ward number
- b. Name
- c. Classification
- d. Religion
- e. Diagnosis
- f. Condition

Distributes copies of list to commanding officer, executive officer, officer of the day, administrative officer, chief of service, records office, information desk, communications office, Red Cross, chaplain, and gate sentry, in accordance with local needs.

PROPOSED LEAVE DESK PROCEDURE

1. Leave requests are initiated by patient or staff officer and enlisted personnel:
  - a. Ward medical officer approves enlisted patients' requests.
  - b. Head of department and personnel officer approve staff patients' requests.
  - c. Chief of SOQ or SOQ medical officer approves officer patients' requests.
  - d. Executive officer authorizes enlisted staff and patient leave, either by request mast or according to local procedure.
  - e. Executive officer authorizes staff and patient officer leave.
  - f. Convalescent, sick, or emergency leave is granted according to particular circumstances of the case. (Emergency leave is verified by the Red Cross.)
2. Executive officer completes and signs leave papers for all personnel. The original is given to the person going on leave, and the duplicate to the leave desk in case of enlisted patients, to the staff enlisted desk in case of enlisted staff, to the officer patient desk in case of officer patients, or to the staff officers desk in case of staff officers.

The following procedure applies to officer patients and enlisted patients, only. Additional "leave" procedures for staff officer and enlisted are listed separately.

3. Patient reports with leave papers, Clinical Chart, and patient's disposition slip from ward or SOQ.
4. Leave clerk prepares file card (3" x 5") on all patient leaves as follows:

Name	Rank	Rate	Type of Leave	Date/Time Leave Commenced	Date/Time Leave Expires	No. Days Leave	Add'l Days on Leave	Ward No.
_____	_____	_____	_____	_____	_____	_____	_____	_____

  - a. Files card separately for officers and enlisted personnel by expiration date of leave.
  - b. Files disposition slip alphabetically, by officer and enlisted categories.
5. Prepares manila envelopes for each patient going on leave, and inserts the Clinical Chart, and a copy of the leave papers therein. Types following information on envelope:

<u>Name</u>	<u>Rank/Rate</u>	<u>Type of Leave</u>	<u>No. of Days Leave</u>
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6. Patients returning from leave report to leave desk with leave papers. Envelope is pulled from file and Clinical Chart and disposition slip given to patient, who returns to previous ward.
  - a. Clerk notes time of return on leave papers and forwards to receipt desk. (Leave ration notices are prepared in the event of emergency leave.) Leave papers are inserted in Service Record at receipt desk, and entry is made on page 5 of NAVPERS-601.)
  - b. Notes time of return on file card, then files, alphabetically, in "inactive" file.
7. Prepares daily Ward Report, NAVMED-HF-9 on all patients going on or returning from leave, and also on those whose terminal leave expires. This report is prepared for the convenience of the Form 10 desk.
  - a. Picks up patients returning from leave as "FT" (from transfer).
  - b. Transfers patients returning from leave from leave desk to previous ward ("TOW").



- c. Transfers patients going on leave from ward to leave desk ("AOW").
  - d. Lists emergency leave as such on the report. Personnel on emergency leave are not counted as being transferred from hospital.
  - e. Shows discharges as "D"; i.e., those whose enlistment dates expire and who are to be "invalided from service" or discharge for the "convenience of the government". (For F card purposes.)
  - f. Types original and four copies of Ward Report. Sends original to Form 10 desk; one copy each to F card desk, information desk, and post office; and puts one copy in desk file.
8. Receives daily discharge lists from discharge desk, fleet reserve transfer desk, and officer patient desk. These lists are maintained in chronological order on a file clipboard.
- a. When terminal leave expires, name of person is eliminated from lists. A daily check of these lists is necessary.
  - b. Information relative to expiration of terminal leave is transcribed to leave desk ward report.
9. Prepares daily memorandum for chief master-at-arms or security officer listing all AOL's according to date of expiration of authorized leaves (original and file copy).
10. Prepares "emergency leave" ration census report on NAVMED-HF-36, daily for ration record desk. Reports personnel on emergency leave as of 0700 daily, by officers and enlisted personnel and by branch of service, i.e., USN. USNR. USMC. USN (RET.). etc.
11. If telegrams for extension of leave are received, this desk obtains approval from executive officer, via personnel officer. If extensions are granted, notifies security officer, ward and person who sent request. If not granted, expedites negative reply to person who sent request.

## PROPOSED PERSONNEL ACCOUNTING DESK PROCEDURE

### PREPARATION OF PERSONNEL ACCOUNTING CARD, NAVPERS-500

1. Clerk prepares a set of NAVPERS-500 cards on all staff and patient naval personnel.
  - a. Files original (roster card) in alphabetical sequence within particular category, i.e., patient officer, patient enlisted, staff officer, staff enlisted.
  - b. Retains #2 copy temporarily for information used in preparation of daily diary.
  - c. Files #3 copy (allowance card) in rate sequence in accordance with instructions for Navy accounting system.

### RECEIPT OF PERSONNEL

1. Staff officers, including nurses, for duty. Staff officer desk forwards #2 copy of NAVPERS-500 to accounting desk each morning listing officers and nurses reporting for duty.
2. Staff enlisted personnel for duty or reporting for discharge (all ratings). Staff enlisted personnel receipt desk forwards #2 copy of NAVPERS-500 each morning listing enlisted personnel reporting for duty.
3. Officer patients, including nurses, for hospitalization. Admission unit forwards #3 copy of NAVPERS-500 listing officers received for treatment.
4. Enlisted patients for hospitalization. Admission unit forwards #3 copy of NAVPERS-500, listing enlisted patients received for hospitalization.

### DISPOSITION OF PERSONNEL

1. Staff officers for transfer, separation, or discharge. Clerk on staff officer desk forwards to personnel accounting desk original NAVPERS-500, which he previously pulled from HC-3 desk, to enter disposition, date, and authorization.
2. Staff enlisted personnel for transfer or discharge (all ratings). Clerk on staff enlisted transfer or discharge desk forwards to personnel accounting desk original NAVPERS-500, which he previously pulled from HC-3 desk file to enter disposition, date, and authorization.
3. Officer patients for discharge from hospital.
  - a. Officer patient clerk forwards #5 copy of Admission Card with disposition, date, and authority entered on card.
  - b. Accounting clerk pulls original NAVPERS-500 from file and enters disposition, date and authority for Admission Card copy. Returns #5 copy of Admission Card to officer patient desk for filing in inactive file after it has served its purpose.
4. Enlisted patients for discharge from hospitals.
  - a. Enlisted transfer or discharge desk forwards #5 copy of Admission Card with disposition, date, and authority entered.
  - b. Accounting clerk pulls original NAVPERS-500 from file and enters disposition, date, and authority. No. 5 copy of Admission Card is then returned to enlisted patient transfer discharge desk for filing in inactive file.



5. Officer or enlisted patient deaths.

- a. Upon being notified of death of patient, officer or enlisted patient transfer desk clerk notes date and time of death on #5 copy of Admission Card. Balance of procedure is same as steps number 3 and 4 immediately above.

6. Final distribution of NAVPERS-500.

- a. Accounting clerk files original NAVPERS-500, with disposition, date, and authority entered, in inactive file.
- b. Forwards #3 copy of NAVPERS-500 (together with #3 copy received from last duty station) on which has been entered disposition, date, and authority, to next station with transference.
- c. Sends #2 copy daily to district personnel accounting office.

THE DAILY DIARY, NAVPERS-501

The Daily Diary is prepared on all naval personnel in accordance with instructions prescribed in the Navy Personnel Accounting Procedural Manual. Separate daily diaries are prepared for staff officers, nurses, and enlisted personnel, and officer and enlisted patients, or as convenient.

1. Personnel accounting clerk prepares original and 5 copies daily. The original is maintained for one month. Each day entries are added to it in sequence, regardless of the number of entries, and five carbon copies are typed.
2. Distributes copies as follows:
  - a. Maintains original for one month, then certifies and sends to Bureau of Naval Personnel via district commandant, as of midnight, the first day of the following month.
  - b. Retains #2 copy for file (not certified).
  - c. Certifies #3 copy daily and sends to district personnel accounting office with that day's #2 copy of the NAVPERS-500 attached.
  - d. Sends #4 copy daily to Fleet Records Office, San Francisco, Calif. (Not certified.)
  - e. Retains #5 copy daily for personnel accounting desk file (not certified).
  - f. Sends #6 copy daily to finance office for military pay purposes (not certified).
3. Receives Form 10 daily to check admissions and discharges of naval personnel against daily diary.
4. Receives NAVPERS-520 from district personnel accounting office monthly, makes necessary corrections, then returns to district.

PROPOSED HC-3 AND HC-4 (STATUS REPORTS) DESK PROCEDURE

1. Form 10 desk forwards Form 10 daily to HC-3 and HC-4 desk. (Data include Hospital Corps officers and enlisted personnel, including staff, admitted to and discharged from the hospital.)
2. HC-3 and HC-4 desk clerk receives original and #3 copy of NAVPERS-500 and #5 copy of Admission Card on all enlisted personnel reporting under orders, other than patients, from the receipt desk. Files original alphabetically and #3 copy by rate.
3. Receives original and #3 copy of NAVPERS-500 on all officers from staff officers desk. Files original alphabetically and #3 copy by rank.
4. Prepares a 3" x 5" file card on all enlisted personnel received for staff who have technician ratings or special qualifications. Card contains following information:
  - a. Name
  - b. Rate
  - c. Technical qualification
  - d. Where detailedForwards card to staff enlisted detail desk for completion of assignment. Card is filed at detail desk according to technical qualification.
5. Receives AOL or disciplinary report for Hospital Corps patients and staff from master-at-arms.
6. Receives discharge list, consisting of medical surveys, discharges for convenience of government, undesirable discharges, etc., from records office discharge desk.
7. Receives information concerning changes in rate, reenlistments, extensions of enlistment, etc., from reports desk in the military personnel office.
8. Prepares Receipt, Transfer, and Status Card, NAVMED-HC-3, on all changes in status of Hospital Corps patients and staff, including dental technicians. Sends original to Bureau of Medicine and Surgery, copy #2 to district medical officer, copy #3 to district dental officer, and copy #4 to file.
9. Files daily changes alphabetically in current section of monthly file. Separate files are kept for officers and enlisted men.
10. At end of month types all NAVMED-HC-3 changes, alphabetically, on face of Roster Report of Hospital Corps, NAVMED-HC-4.
11. Types reverse side of HC-4. All changes in current month, which include transfer of personnel remaining from previous months, are placed in "inactive" or "transferred" files. Files all remaining Hospital Corps personnel cards, including balance from previous month, separately for officers and enlisted personnel.
12. Checks NAVMED-HC-4's against NAVPERS-500's in Kardex file to verify personnel remaining on board.
13. Prepares memorandum for disbursing officer (usually a local form) at time enlisted personnel report for staff duty, listing following information:
  - a. Name in full
  - b. Rank or rate and classification
  - c. Date reported
  - d. Pay entry base or total service
  - e. Date longevity increase is due
  - f. Status (married or single)
  - g. Amount contributed by government for family allowance (enlisted)



- h. Amount of commuted rations (enlisted)
  - i. Amount of MAQ (enlisted)
  - j. Department, ward, etc., to which assigned
15. Prepares memorandum for disbursing office (usually a local form) as changes in status occur, with following information:
- a. Name in full
  - b. Rank or rate of classification
  - c. Change (description)
    - 1. Reassigned to
    - 2. Married or divorced
    - 3. Change of rank or rate to
    - 4. Admitted to sick list
    - 5. Discharged from sick list and reassigned to
    - 6. Departed on \_\_\_\_\_ days leave
    - 7. Returned from leave and reassigned to
    - 8. Departed on temporary additional duties to
    - 9. Returned from temporary additional duties at \_\_\_\_\_ and returned to \_\_\_\_\_
    - 10. Transferred from this command to
16. Files #5 copy of Admission Card, alphabetically, to maintain record of staff enlisted men on sick list. Receives information relative to discharge from detail desk.
17. Maintains roster list of staff enlisted personnel "under instruction" on separate file cards, which include name, rate, and course, for HC-4 purposes.
18. Pulls original and #3 copies of NAVPERS-500 on staff officers and enlisted men and closes form out, by entering disposition and date on both copies. Copy #3 is placed in the officer's qualification jacket and/or service record. Original is sent to the personnel accounting desk, then returned to this desk for the preparation of the HC-3 and subsequent filing.
19. Prepares Sick List, NAVMED-T, for daily distribution.

PROPOSED DETAIL DESK PROCEDURE

1. HC-3 desk notifies detail desk regarding staff enlisted personnel admitted to sick list.
2. Detail clerk receives morning muster report from wards, heads of divisions and services, or their designated representatives, on all enlisted personnel. All absentees are noted.
3. Prepares morning report on all staff enlisted personnel for Form 10 desk in the records office. Report includes men and women on duty, under instruction, on leave or temporary duty, on sick list, and on commuted rations. Information on report dates from beginning of previous day and includes all changes for previous day.
4. Types 3" x 5" muster card for all staff enlisted personnel and files alphabetically. (Uses copy of this card for "detail" card.) Card contains following information:

Name	Rate	Date Reported	Section	Detail
------	------	---------------	---------	--------
5. Maintains 3" x 5" detail card (#2 copy of muster card) on all staff enlisted personnel, by type of detail.
6. Receives 3" x 5" technical qualification card from HC-3 desk on staff enlisted personnel reporting. Posts "details" and files by technical qualification.
7. Prepares "daily change" memorandum on all staff enlisted men reporting for duty, added to or returning from sick list, going on or returning from leave, and all changes in assignments.
8. Prepares "detail assignment chits" showing name, grade, new detail and section assigned, and date and time of reporting for new assignment.
  - a. Enlisted man reports from detail desk to ward nurse, head of division or service, or designated representative with "detail assignment chit."
  - b. Person to whom man reports signs "chit" and returns it to detail desk. On this basis, proper liberty cards are prepared for the liberty desk.
9. Posts all changes in detail assigned, including date of each new assignment, to both muster card and detail card by 2100 each day. Posts all other changes to these cards, e.g., admission to sick list, return from sick list, captain's mast, AOL, AWOL, temporary duty, etc. (Detail card remains on file while man is hospitalized, on leave, etc.)
10. Prepares daily list of personnel available for special watches after 2100 for night master-at-arms.
  - a. Petty officers, second class, and lower rates are utilized for four-hour watches. Ward corpsmen should not stand these watches.
  - b. Ward medical officer originates requests for special watch, with approval of the chief of service and the executive officer.
11. Prepares for officer of the day daily "utility" watch list, primarily for the ambulance watch, for duty between 1630 and 2200. Only personnel whose day ended at 1630 are placed on this list.
12. Requests for leave:
  - a. Man submits request for special liberty or leave to detail desk. Request is previously approved by ward medical officer or head of service or division.
  - b. Request is submitted to personnel officer for approval, then via request mast to executive officer for approval.



- c. Executive officer signs leave papers (in duplicate). Original is sent to staff enlisted desk, and copy to detail desk.
  - d. Detail clerk makes entries from leave papers on muster and detail cards, then files copy of leave papers, alphabetically.
  - e. The balance of the leave procedure is discussed under the "leave desk."
13. Prepares four copies of NAVS&A-518 for leave granted on orders. (Information is obtained from leave papers after enlisted man returns.) Places original in Service Record, forwards two copies to the disbursing office, and sends one copy to the Bureau of Naval Personnel.

## PROPOSED STAFF OFFICER DESK PROCEDURE

### REPORTING FOR DUTY:

1. Officers, including nurses, who are reporting for staff duty, "log in" with officer of the day.
2. Officer reports to records office for endorsement of orders. Turns in Health Record and Officers Qualification Jacket.
3. Staff officer desk clerk prepares memorandum stating that officer has reported. (Authorization - Circular Letter 44-47.) Sends original to Bureau of Naval Personnel and copies to Bureau of Medicine and Surgery and district commandant.
4. Officer reports to pay office with original orders, and necessary copies for pay account and travel claim. (Additional copies of orders, if necessary, are prepared by clerk at staff officer desk.)
5. Clerk removes Officer's Leave Record, NAVPERS-329, from Officers' Qualification Jacket, files, alphabetically, in a separate file. All leaves are recorded on this form.
6. Removes #3 copy of Personnel Accounting Card, NAVPERS-500. from Officers' Qualification Jacket.
  - a. Makes corrections, if necessary.
  - b. Types a set of three NAVPERS-500 forms. Sends original and #3 copy to HC-3 desk (regardless of Corps of officer) and #2 copy to personnel accounting office, immediately.
7. Enters date of reporting on Health Record.
8. Prepares Report of Beneficiaries, NAVPERS-601 (page 7).
9. Prepares original and copy of Officer Data Card, NAVPERS-340. Sends original to Bureau of Naval Personnel and files copy in jacket.
10. Prepares Affidavit for Naval Reserve, NAVPERS-1407, for officers reporting for first duty (for pay purposes).
11. Prepares Appointment in Naval Reserve, BNP-962, (oath of office for officers reporting for first duty).
12. Prepares Officers' Qualification Jacket (first duty officers).
13. Types initial NAVPERS-500 forms (first duty officers). Forwards to personnel accounting desk.
14. Prepares Uniform Gratuity, NAVS&A-445A (for initial gratuity and subsequent gratuities every four-years, when necessary).
15. Sends daily memorandum of staff officer census to Ration Record (HF-36) desk.
16. Sends daily memorandum of staff officer changes for the day to Form 10 desk.
17. Types Fitness Report, NAVPERS-310-A, of staff officers, or letters in lieu of fitness reports for temporary duty.
18. Prepares Roster of Officers, NAVPERS-353. (Daily changes are recorded on a "working" copy of previous report, and transposed to a "smooth" copy at the end of the month.)
19. Types leave requests, resignations, statements of longevity, letters of commendation, commissary card, and Dependent's Identification Card, NAVMED-562.



20. Maintains Immunization Record, NAVMED-585, alphabetically on file. Checks monthly for booster "shots."
21. Prepares Certificate of Assignment of Quarters or Termination Thereof, NAVS&A-532, as needed.
22. Prepares Roster Report of Medical Corps, NAVPERS-953, monthly. Sends original and two copies to the Bureau of Medicine and Surgery, and files one copy.
23. Prepares Blanket Certificate of Assignment of Quarters, NAVS&A-533, monthly for all staff officers.
24. Prepares Medical Officers Under Instruction (Other than Interns), NAVMED-949. Sends original and two copies to the Bureau of Medicine and Surgery, and files one copy.
25. Maintains alphabetical file of 3" x 5" file cards on all officers, except nurses. An extra copy is prepared for information desk. The card is set up as follows:

Name	Rank
Classification	File Number
Date Reported	Specialty
From	Assignment
Authority	
Present Shore Duty	

#### DETACHED FROM DUTY:

1. Clerk receives orders detaching staff officer. Notifies officer concerned.
2. Cuts stencil of orders and has 30 copies printed.
3. Prepares Application for Transportation of Household Effects, NAVS&A-34. Receives transportation requests from disbursing office.
4. Pulls officer's envelope from file; dates Health Record; completes Officer Qualification Jacket, Officer's Leave Record, Immunization Record and orders; and delivers all papers to officer.
5. Obtains original and #3 copy of NAVPERS-500 from HC-3 desk, and enters disposition, date, and authority thereon. Files #3 copy in Officer's Qualification Jacket. Sends original to the personnel accounting clerk, who returns it to the HC-3 desk for completion of HC-3 card, if necessary, then files. Posts date detached, disposition, and authority to officer's file card. Files card in inactive file.
6. Logs officer out. Closes out jacket in file.

#### SEPARATION FROM ACTIVE SERVICE:

1. Clerk receives orders and notifies officer concerned. Prepares endorsement of separation. Makes stencil of orders, if necessary, and has copies printed.
2. Pulls Leave Record and #3 copy of NAVPERS-500. Officer reports to civil readjustment office, where clerk prepares brochures and separation forms.
3. Prepares Report of Physical Examination. Receives endorsement and makes stencil, if necessary.
4. Prepares Mustering Out Pay forms, and sends to disbursing office. Computes number of days terminal leave, and expiration date, and specifies on orders.
5. Makes Health Record entries.

6. Delivers orders.

7. Personnel accounting procedure is the same as step 5 under "Detached From Duty" above.

MISCELLANEOUS

1. Staff officer clerk prepares station roster of all staff officers.

2. Receives #5 copy of Admission Card from admission unit for staff officers admitted to sick list. Maintains daily work sheet of staff officers on sick list on NAVMED-172 for "F" card desk.



PROPOSED PROCEDURE FOR RECEIPT TRANSFER, DISCHARGE, AND REENLISTMENT (STAFF ENLISTED) DESK

RECEIPT (STAFF ENLISTED)

1. Enlisted man reports for staff duty with Standard Transfer Orders, Pay Account, Health Record, Service Record, Continuous Service Certificate, and #3 copy of NAVPERS-500. All of these documents are from the previous duty station.
2. Records officer endorses NAVPERS-601, page 9-Y, of Service Record. Files original endorsement in Service Record, and sends copy to Bureau of Naval Personnel.
3. Receipt clerk posts name of hospital and date of reporting on pay account.
4. Endorses Standard Transfer Orders. Places original in the Service Record, sends copy to last duty station, and files copy.
5. Makes entry in Health Record. Stamps Abstract of Service, NAVMED-H-5, with name of hospital and date reported. Files Health Record alphabetically. (Chief pharmacist's mates ratings are filed separately.)
6. Removes #3 copy of NAVPERS-500 from Service Record. Checks against Service Record and makes corrections after consulting with enlisted man. Types new set of NAVPERS-500 forms in triplicate. Sends original and #3 copy to HC-3 desk, and #2 copy to personnel accounting desk. Upon return from HC-3 desk, files original alphabetically and #3 copy by rate.
7. Removes Quarterly Mark Cards, BNP-618, from Service Record and files alphabetically.
8. Places tab on #3 copy of NAVPERS-500, in lieu of 3" x 5" card, for enlistment expiration purposes, in accordance with personnel accounting procedure.
9. Requests U. S. Navy Immunization Record, NAVMED-585, from enlisted man or, if record is not available, prepares one. Checks against Health Record, if necessary, to determine inoculations received. Files record alphabetically.
10. Sends Service Record and Pay Account to disbursing office with original and copy of memorandum of transmittal. Disbursing office receipts copy of memorandum and returns to receipt clerk who files it alphabetically. A tally or receipt card is used to check out Service Record.
11. Notes return of Service Record on file tally card and files Service Record alphabetically. (Chief pharmacist's mates ratings are filed separately.)

TRANSFERS

1. Bureau of Naval Personnel or district commandant sends orders for enlisted personnel by dispatch, speedletter, or ordinary letter.
2. Clerk contacts transportation office for probable date of available transportation.
3. Notifies enlisted personnel concerned of orders.
  - a. Enlisted man is given physical examination in admissions ward. Form NAVMED-Y is prepared and entered in Health Record.
4. Clerk closes out Health Record 24 hours prior to departure.
  - a. Enters date of detachment in NAVMED-H-5.
  - b. Enters "Examined and Found Qualified for Transfer" in NAVMED-H-8.



5. Transferee checks out with bag room, barracks, master-at-arms, library, and security officer. Check-out sheet is placed in Service Record when completed.
6. Clerk pulls Service Record from file. Obtains original and #3 copy of NAVPERS-500 from HC-3 desk. Enters disposition, date, and authority on each. Places #3 copy of NAVPERS-500 in Service Record and sends original to personnel accounting clerk, who returns it to HC-3 desk for completion of HC-3 information.
7. Pulls Quarterly Mark Card from desk file, and enters in Service Record.
8. Pulls Immunization Card, NAVMED-585, and qualification card from file, and enters in Service Record.
9. Closes out page 5, Proficiency and Conduct, NAVPERS-601, after obtaining information for marks from Quarterly Mark Card. Enters page 5 in Service Record.
10. Prepares page 9-Y of Orders for Destination, NAVPERS-601. Places in Service Record.
11. Prepares Standard Transfer Order, with distribution as follows: Original and copies #2 and #3 to transferee in sealed envelope; copy #4 to Service Record of each transferee; copy #5 to new duty station (mailed); copy #6 to district commandant; copy #7 to desk file, and copies #8 and #9 to disbursing office.
12. Disbursing office closes out pay account. Sends papers to staff enlisted transfer desk for final entry of date of departure.
13. Places original and copies #2 and #3 of Standard Transfer Orders, Pay Account, Service Record, and Health Record in an envelope. Gives envelope to enlisted man or senior petty officer of the draft for delivery to new duty station.
14. Mails necessary copies of Standard Transfer Order to new duty station.
15. Transferee or senior petty officer of draft signs #7 copy of Standard Transfer Order. This copy is placed in file and later destroyed when replaced by signed copy of Standard Transfer Order with signature of commanding officer of next duty station.

#### DISCHARGE

1. Enlisted personnel report for discharge from previous command with Standard Transfer Order, Pay Account, Health Record, Service Record, Continuous Service Certificate, and #3 copy of NAVPERS-500.
2. Records officer endorses NAVPERS-601, page 9-Y, of Service Record. Places original in Service Record and sends copy to Bureau of Naval Personnel.
3. Disbursing office does not "pick up" Pay Account until dischargée is ready to leave hospital.
4. Records officer endorses Standard Transfer Order. Files original in Service Record, sends copy to former station and places copy in hospital file.
5. Clerk makes entry in Health Record. Stamps "abstract of service."
6. Schedules dischargée for physical examination. Report of Physical Examination is completed, and entry is made in Health Record.
7. Dischargée assists in preparation of Notice of Separation from Service, NAVPERS-553.
8. Dischargée reports to civil readjustment and educational offices for indoctrinational lectures, brochures, etc.
9. Clerk types separation orders and computes terminal leave.



10. Completes original and copy of pages 9 and 10 of NAVPERS-601, with discharge information, authority for discharge, mileage information, terminal leave information, professional qualifications, conduct and marks.
11. Completes original and three copies of pages 11 and 12 of NAVPERS-601 (Orders to Close Account).
12. Prepares Presidential Testimonial.
13. Prepares original and three copies of Medical Officer's Pay, NAVS&A-550.
14. Prepares original and four copies of Statement of Claim for Settlement for Unused Leave.
15. Types discharge certificate. Makes entry in log of serial number of honorable discharge certificate, as follows:

C.O.#	Enl.Date	Discharge Date	Name	Rate	Ser.#	Place of Enl.	Type of Discharge	Cert. #

16. Types Certificate of Satisfactory Service, NAVPERS-554.
17. Types Change of Address, NAVPERS-693.
18. Types Reserve I. D. Card, NAVPERS-904, if man is going to inactive duty.
19. Receives signatures of dischargee and personnel officer on NAVPERS-553, NAVS&A-550, and NAVPERS-554.
20. Sends Pay Account, NAVPERS-553, NAVS&A-550, pages 11 and 12 of NAVPERS-601, and separation orders to disbursing office.
21. Checks #3 copy of NAVPERS-500. Types new set of NAVPERS-500 when enlisted man reports for discharge. Sends original to HC-3 desk, (after return, files alphabetically), #2 copy to personnel accounting desk, and #3 copy to HC-3 desk (after return, files by rate).
22. Enlisted man leaves with copy of separation orders, #5 copy of NAVPERS-553, and NAVPERS-554.
23. Clerk prepares "Official Records" envelope with name, date of departure on terminal leave, and terminal leave expiration date. Inserts President's Testimonial, discharge certificate; original and last copy of NAVPERS-553, original Service Record, copy of orders and emblem.
24. Completes Health Record and forwards to Bureau of Medicine and Surgery. Closes out Service Record and sends to Bureau of Naval Personnel, upon expiration of person's terminal leave.
25. Mails balance of material in "Official Records" envelope to dischargee.
26. Obtains original and copy #3 of NAVPERS-500 from HC-3 desk. Enters disposition, date, and authority on each. Files copy #3 in Service Record. Sends original to the personnel accounting clerk, who returns it to the HC-3 desk for completion of the HC-3, then files.

#### REENLISTMENT

1. Staff enlisted man reports to admission unit medical officer with "rough" NAVMED-Y, for physical examination. Subsequently reports to EENT and dental service for completion of examination.

2. Clerk completes Shipping Articles, NAVPERS-603.
3. Prepares page 11 of NAVPERS-601 (Order to Close Accounts) and lists previous duty stations on reverse side.
4. Takes fingerprints for NAVPERS-601, pages 3 and 4.
5. Types "smooth" NAVMED-Y.
6. Closes out old NAVPERS-601, page 2, as well as NAVMED-H-8 and NAVMED-H-1.
7. Opens new NAVPERS-601, page 2, and NAVMED-H-8 and NAVMED-H-1.
8. Obtains medical officer's signature on all necessary forms above.
9. Obtains signature on Shipping Articles.
10. Completes "recruiting file" record, NAVMED-X.
11. Completes NAVPERS-601, page 1 (Order to Open Accounts).
12. Opens NAVPERS-601, page 5 and 5a (Leave).
13. Enters on NAVPERS-601, pages 9 and 10, date of discharge from previous tour of duty, reenlistment endorsement, and list of campaigns and medals.
14. Completes NAVMED-HC-3. Sends one set to discharge desk and one set to reenlistment desk.
15. Closes out old Service Record cover, and Service Record, except NAVPERS-601, pages 4, 4a, and 4b. Sends closed-out Service Record to Bureau of Naval Personnel on same day as reenlistment is effective. Prepares new Service Record - also new items, plus old pages 4, 4a, and 4b. Prepares new Health Record cover, new NAVMED-H-1, and H-5, and new dental pages. Sends old NAVMED-H-2 and all abstracts of previous medical histories to Bureau of Medicine and Surgery.

#### REPORTS, LETTERS, AND FORMS

##### 1. Weekly

- a. Clerk forwards letter report to Bureau of Medicine and Surgery, subject, "Enlisted Personnel Hospital Corps, USN and USNR, on board for duty and Instruction, Report of", as of midnight on Saturday. (Reference: Despatch 14 June 1946 - 141700Z.)
- b. Weekly Morbidity Report, NAVMED-172.
  - (1) Daily worksheet is kept at HC-3 desk from #5 copy of admission cards of staff enlisted men admitted to sick list: Name, rate, service number, diagnosis, and diagnosis number.
  - (2) Each week, as of 2400 Saturday, HC-3 desk makes entries in pencil on NAVMED-172, and forwards to F card morbidity report desk for typing and completion.
- c. Sends letter report to district medical officer, entitled, "Combined Report of Enlisted Hospital Corps for Week Ending Midnight \_\_\_\_\_."

##### 2. Monthly

- a. Sends letter report to Bureau of Naval Personnel, subject "Assignment and Housing Hospital Corps Personnel, Monthly Report of." (Reference: BuMed ltr NH/14-1, BuMed H-3 EJE, dtd 18 Nov 1943.)



3. Bimonthly

- a. Forwards letter report to Bureau of Naval Personnel, subject "Enlistments and Reenlistments for period \_\_\_\_." Sends original and two copies to Bureau of Naval Personnel, one copy to central hospital files, and one copy to desk file.

4. Quarterly

- a. Prepares staff enlisted men's portion of Hospital Bed Capacity Report, NAVMED-103.

5. As Required

- a. Prepares Dependents Identification Card, NAVMED-562, at request of staff enlisted men, or of personnel office, periodically.
- b. Sends letter, subject "Issuance of Certificate of Special Instruction and Orders for Assignment, Request for" to Bureau of Naval Personnel via Bureau of Medicine and Surgery two weeks prior to completion of instruction of corpsman. (Reference: BuMed C/L 45-18.)
- c. Sends letter to head of department giving instructions to corpsman under instruction, and authorizing issuance of Certificate of Special Instruction.
- d. Prepares NAVS&A-515, page 9x, regarding: (1) Change in Rate or Reserve Class, and (2) Change in Longevity for Pay Purposes.
- e. Forwards NAVPERS-601, pages 7 and 8, (Beneficiary Slip) for change in beneficiary. Sends original to Bureau of Naval Personnel and two copies to disbursing office.
- f. Completes Certificate of Special Instruction, NAVMED-703. Enters data on NAVPERS-601, page 9, of Service Record.
- g. Prepares Application for Family Allowances, NAVPERS-668.
- h. Course books and training. Maintains bound register of types and number of books issued. Upon return of books and progress test, grades test, logs marks in NAVPERS-601, pages 9 and 10, and issues certificate (BNP-672).

APPENDIX II  
EXHIBITS AND TABLES FOR INDIVIDUAL HOSPITALS





## CONTENTS

	<u>Page</u>
<u>EXHIBITS</u>	
24. Proposed Health/Service Record Receipt	433
25. Proposed Revision of Personal Effects Tag, NAVMED-HF-22	434
<u>STATISTICAL TABLES FOR INDIVIDUAL HOSPITALS</u>	
60. Distribution of Staff - Portsmouth, Va.	435
61. Distribution of Staff - Philadelphia	436
62. Distribution of Staff - Great Lakes	437
63. Distribution of Staff - San Diego	438
64. Distribution of Staff - Newport	439
65. Percentage Distribution of Total Staff - Portsmouth	440
66. Percentage Distribution of Total Staff - Philadelphia	441
67. Percentage Distribution of Total Staff - Great Lakes	442
68. Percentage Distribution of Total Staff - San Diego	443
69. Percentage Distribution of Total Staff - Newport	444
70. Maintenance Division, Shops and Grounds Section - Portsmouth	445
71. Maintenance Division, Shops and Grounds Section - Philadelphia	446
72. Maintenance Division, Shops and Grounds Section - Great Lakes	447
73. Maintenance Division, Shops and Grounds Section - San Diego	448
74. Maintenance Division, Shops and Grounds Section - Newport	449
75. Commissary Division - Portsmouth	450
76. Commissary Division - Philadelphia	451
77. Commissary Division - Great Lakes	452
78. Commissary Division - San Diego	453
79. Commissary Division - Newport	454
80. Main Operating Room - Portsmouth	455
81. Main Operating Room - Philadelphia	456
82. Main Operating Room - Great Lakes	457
83. Main Operating Room - San Diego	458



84. Main Operating Room - Newport	459
85. Dental Service - Portsmouth	460
86. Dental Service - Philadelphia	461
87. Dental Service - Great Lakes	462
88. Dental Service - San Diego	463
89. Dental Service - Newport	464
90. EENT Service - Portsmouth	465
91. EENT Service - Philadelphia	466
92. EENT Service - San Diego	467
93. EENT Service - Newport	468
94. X-Ray Service - Portsmouth	469
95. X-Ray Service - Philadelphia	470
96. X-Ray Service - Great Lakes	471
97. X-Ray Service - San Diego	472
98. X-Ray Service - Newport	473
99. Laboratory Service - Portsmouth	474
100. Laboratory Service - Philadelphia	475
101. Laboratory Service - Great Lakes	476
102. Laboratory Service - San Diego	477
103. Laboratory Service - Newport	478
104. Nurses at Portsmouth	479
105. Nurses at Philadelphia	480
106. Nurses at Great Lakes	481
107. Nurses at San Diego	482
108. Nurses at Newport	483
109. Distribution of Staff Corpsmen - Portsmouth	484
110. Distribution of Staff Corpsmen - Philadelphia	485
111. Distribution of Staff Corpsmen - Great Lakes	486
112. Distribution of Staff Corpsmen - San Diego	487
113. Distribution of Staff Corpsmen - Newport	488

	<u>Page</u>
114. Dependents Service - Portsmouth	489
115. Dependents Service - Philadelphia	490
116. Dependents Service - Great Lakes	491
117. Dependents Service - San Diego	492
118. Dependents Service - Newport	493










**PERSONAL EFFECTS TAG** No. 360154  
 NAVMED-HF-22 (REV 7-45)

NAME \_\_\_\_\_

RATE		SERVICE NO.	DATE REC'D.
STORAGE NO.	HANDS ON NO.	SUITCASE	BAG
FT. LOCKER	DITTY BAG	ETC.	
DISPOSITION		DATE DISPOSED	
U. S. NAVAL HOSPITAL			

No. 360154

U. S. NAVAL HOSPITAL

NAME \_\_\_\_\_

RATE		SERVICE NO.	DATE REC'D.
STORAGE NO.	HANDS ON NO.	SUITCASE	BAG
FT. LOCKER	DITTY BAG	ETC.	

This identification card must be presented to the bag-room keeper when access to your personal effects is desired.

TABLE 60

DISTRIBUTION OF STAFF, PORTSMOUTH - JANUARY 1946 - NOVEMBER 1946

(C = civilian; M = military)

	Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		
	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	
Finance	18	24	18	18	16	18	17	16	17	15	15	16	13	11	13	12	14	8	14	12	14	8	
Disbursing	17		17		17		18		18		6		6		6		6		6		6		
Personnel & Records	26	49	24	42	22	33	23	35	22	36	15	29	15	27	13	27	13	26	12	23	12	20	
Welfare & Rec.		17		11		10		7		5		1		2		1		2		2		2	
Commissary	150	53	177	35	174	22	174	18	167	16	157	10	150	7	114	8	108	10	106	9	104	7	
Maintenance	2	7	2	6	2	4	2	4	2	4	1	3	1	2	1	2	1	2	1	1	1	1	
Laundry	39	6	39	4	40	5	40	4	34	5	28	3	27	2	25	2	25	2	25	2	11	2	
Transportation	14	11	15	10	15	10	15	8	15	6	15	4	15	7	10	9	10	8	10	8	10	8	
Power Plant	13		14		14		14		14		14		14		14		14		14		14		
Fire Department		15		14		18		17		15		8		5	10	5	10	5	9	5	9	8	
Shops & Grounds	87		91		92		94		93		84		73		65		62		61		59		
Guards - MAA		47		31		21		14		13		12		13	10	13	13	13	19	13	15	13	11
Telephone	12	6	12	5	12	2	13		13		11		11		11		11		11		11		
Staff Qtrs.	25		25		25		23		22		10		8		6		6		6		6		
Library	5	4	5	2	5	1	3		3		2		2		2		1		1		1		
Admin. Services	2	15	3	14	3	10	3	10	3	10	2	9	2	5	1	6	1	5	1	6	1	6	
Surg. MOR; CSS		14		13		13		14		9		9		13		15		13		14		10	
Medical ECG		2		2		2		4		4		7		5		5		1		1		1	
EENT		8		7		8		7		5		3		4		4		4		4		4	
NP Wards & Cler.		31		28		20		23		13		4		10		8		11		11		9	
Dental		27		18		13		14		12		5		9		9		7		7		6	
Dependents (exc. Nurses)	13	25	15	27	15	21	16	21	16	19	14	14	10	11	8	17	11	16	12	11	12	10	
X-Ray	1	7	1	7	1	7	1	6	1	4	1	3	1	4	1	6	1	6	1	6	1	6	
Laboratory		14		11		11		10		11		11		9		7		7		7		6	
Pharmacy		5		5		4		2		5		3		3		3		3		3		3	
Rehab. & Civil Read.		18		7		8		6		7		3		1		0		1		1		2	
Occ. Therapy		11		6		6		3		3		1		1		1		1		1		1	
Physiotherapy		5		5		4		2		1		1		1		3		3		2		2	
Miscellaneous		17		10		4		3		5		4		2				1					
Leave & Sick		26		17		19		20		10		15		7		10		16		18		28	
Ward Corpsmen		136		118		121		121		145		95		69		87		76		76		74	
Total Civilian	427		461		460		460		444		391		368		309		303		300		299		
Total Enlisted	598		463		410		382		369		269		227		253		246		243		238		
Total Nurses	246		208		178		157		130		115		109		59		41		43		44		
Total Officers (est.)	54		58		62		61		57		55		55		49		45		44		39		
Total Staff	1320		1190		1110		1060		1000		830		760		670		640		630		610		
Staff/Patient	1.12		.99		1.03		1.05		1.07		.94		.88		1.08		1.09		1.18		1.32		



TABLE 61

DISTRIBUTION OF STAFF, PHILADELPHIA - JANUARY 1946 - FEBRUARY 1947

(C = civilian; M = military)

	Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		
	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	
Finance	17	17	17	24	17	18	17	21	17	21	17	19	18	20	17	26	15	24	15	22	15	17	15	12	15	12	15	13	
Disbursing	11		11		11		11		11		11		11		11		11		11		11		11		11		11		
Pers. & Recs.	38	61	46	60	42	72	42	66	43	59	43	59	37	55	35	42	22	33	26	34	31	33	27	27	27	26	27	20	
Wel. & Recd.		5		4		5		4		4		4		2		3		3		4		4		3		3		3	
Commissary	234	119	259	131	261	130	263	115	270	87	271	68	261	61	232	64	206	42	201	35	191	25	190	22	182	18	182	17	
Maintenance		9		6		6		6		3		3		3		3		8		8		9		7		6		6	
Laundry	47	6	46	5	46	2	47	4	46	4	44	3	40	6	34	5	34	5	35	4	34	5	34	3	34	3	34	2	
Garage	26	16	30	16	30	15	32	11	34	9	31	12	33	12	27	7	25	9	21	8	21	6	21	4	21	5	21	4	
Power Plant	18		18		15		15		15		15		15		14		12		12		12		12		11		11		
Shops & Grds.	112		112		112		110		111		116		110		108		110		73		69		68		66		65		
Janitors	9		9		9		9		9		9		9		9		9		9		9		9		9		9		
Admin. Services	8	32	8	15	8	16	8	12	8	17	8	18	8	18	8	13	8	7	7	7	7	7	7	7	7	6	7	3	
Security - MAA	10	34	10	37	11	43	11	30	11	28	11	36	11	34	11	26	9	26	9	28	9	25	11	15	11	13	11	16	
Elev. Oprs.	5		6		6		6		6		6		6		6		6		6		6		6		6		6		
Staff Qtrs.	6		6		6		12		12		12		12		11		9		8		8		9		10		7		
Library	3		4		4		4		4	1	3	1	3		3		3		3	2	2	1	2		2	2	2	2	
Telephones	5		5		5		5		5		5		5		5		6		6		6		6		6		6		
Surg. MOR & CSS		32		37		38		36		33		39		27		26		34		33		25		29		28		28	
Art. Limb	2	32	3	30	3	37	3	35	3	39	3	38	3	32	3	30	3	25	3	24	3	19	3	16	3	16	3	15	
Med. Heart Sta.		6		7		9		7		5		4		4		4		3		3		2		2		2		2	
EENT		13		13		17		15		17		17		19		19		16		14		12		10		14		13	
NP		17		23		13		10		10		17		10		9		12		11		9		9		8		7	
Dental	1	9	1	13	1	22	1	17	1	19	1	22	1	14	1	17	1	16	1	16	1	14	1	12	1	14	1	12	
Dependents	7	5	7	32	7	39	7	34	7	38	7	36	7	53	7	35	7	18	7	21	7	17	7	19	7	23	7	21	
X-Ray	2	14	2	20	2	19	2	17	2	23	2	21	2	20	2	19	2	16	2	18	2	19	2	15	2	14	2	13	
Lab. & Epidem.	2	41	2	36	2	44	2	45	2	39	2	42	2	43	2	37	2	21	2	25	2	24	2	26	2	24	2	24	
Pharmacy		6		9		11		11		11		9		8		11		10		10		8		8		7		6	
Occ. Therapy		10		10		11		9		7		5		5		4		3		3		3		2		2		2	
Physiotherapy		16		21		24		20		19		23		15		17		18		19		16		15		11		11	
Ward Corpsmen	280		350		350		320		270		270		350		320		300		250		230		210		160		160		
Sick & Leave	50		30		45		10		17		37		20		20		15		15		12		10		30		10		
Miscellaneous	124		2 109		2 96		2 94		2 55		2 56		2 51		2 41		3 28		3 28		5 23		5 20		5 18		5 18		
Total Civilian	556		599		599		605		615		615		592		544		499		461		445		442		437		432		
Total Enlisted	993		1090		1106		939		849		887		887		819		721		665		583		515		458		415		
Total Nurses	362		361		323		287		260		250		170		127		72		77		72		71		70		70		
Total Officers	127		135		141		146		179		166		161		128		117		113		79		77		75		75		
Total Staff	2030		2180		2170		1980		1900		1910		1810		1620		1410		1310		1180		1110		1040		1000		
Staff/Patient	.67		.80		.82		.81		.83		.95		.98		1.04		.96		.95		.91		.91		.86		.81		

TABLE 62

DISTRIBUTION OF STAFF, GREAT LAKES - JANUARY 1946 - FEBRUARY 1947

(C = civilian; M = military)

	Jan		Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb	
	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M
Finance	27	37	27	46	25	48	25	44	25	46	27	43	27	28	25	34	21	30	21	16	21	11	21	13	21	19	18	19
Disbursing	24	40	25	35	22	30	18	11	16	8	16	6	14	12	13	3	9	3	10	3	7	5	7	3	7	5	7	5
Pers. & Records	84	244	81	240	81	206	70	145	70	122	67	121	60	86	53	125	33	102	27	74	26	42	26	37	24	34	23	40
Wel. & Rec.		15		17		23		27		17		14		12		36		33		25		10		9		9		9
Commissary	187	199	204	194	228	164	228	97	221	56	182	41	169	30	137	33	130	31	128	23	86	16	80	11	84	15	83	17
Maintenance	2	10	2	5	2	2	2	1	2	2	2	2	2	2	1	3	1	3	1	2	1		1	2	1	1	1	2
Laundry	54	45	56	42	58	38	56	24	56	13	53	10	30	10	30	15	25	15	23	14	17	4	15	2	15	3	15	3
Transportation	42	23	42	20	41	22	38	14	39	12	41	12	38	8	37	7	24	7	22	7	15	8	14	2	14	3	14	5
Power Plant	20		19		19		20		18		20		20		19		20		19		19		20		20		20	
Fire Dept.																							10		10		10	
Shops & Grds.	117		113		111		102		107		85		102		52		66		62		58		52		51		53	
Admin. Services	4	23	4	23	4	17	4	15	4	10	4	8	4	9	3	7		5	3	10	3	6	3	6	3	7		5
Post Office	14	17	15	15	12	10	10	6	6	10	2	10		8		19		17		14		5		3		3		3
Security - MAA		101		102		73		98		70		53		46		87		54		45				16		16		22
Quarters	16	25	17	20	21	24	20	5	20		18	11	14	10	13		12	20	11	7	11	1	12	1	12	2	11	
Library	10	1	10	1	9	1	9	1	9	1	8	1	8	1	5	1	5	1	2	1	2	1	2	1	2	1	2	1
Telephone																			6		6		6		2		2	
Ward Corpsmen		768		787		710		513		367		309		261		299		253		255		134		121		99		96
MOR & CSS		71		66		58		42		44		43		29		34		31		25		16		16		13		11
ECG - Med.		10		7		6		5		5		5		5		5		5		3		2		2		1		3
NP		17		17		17		18		9		8		15		22		15		10		4		7		4		4
EENT		16		15		13		12		12		10		6		9		8		5		3		3		4		6
Dental		11		19		15		7		11		10		6		13		15		11		12		8		5		6
Dependents	7	30	6	28	7	27	9	21	9	28	9	24	6	23	7	30	8	35	5	31	6	26	6	29	7	25	7	26
X-Ray		24	1	20	1	25	1	25	1	14	1	23	1	14	1	21	1	19	1	17	1	13	1	11	1	11	1	11
Laboratory	1	42	1	47	1	49	1	33	1	31	1	27	1	15	1	20		18		14		10		14		10		9
Pharmacy		11		12		12		7		4		4		4		9		6		5		3		2		3		3
Rehab. & Civ. Read.	1	15	1	16	1	18	1	6	1	7	1	10	1	9	1	15	1	21	1	18	1	11	1	8	1	11	1	9
Occ. Therapy		12		9		9		6		6		4		2		2		2		2		1		1		1		2
Phys. Therapy		24		21		20		14		8		7		8		11		9		8		11		9		7		7
Miscellaneous		6		7		8		10		7		8		12		8		15		12		11		12		5		5
Sick & Leave		149		178		151		136		113		55		22		19		56		87		127		10		11		23
Total Civilian	609		624		641		613		604		537		497		397		359		343		280		279		276		272	
Total Enlisted	2000		2000		1800		1290		1010		850		690		890		840		750		510		370		330		350	
Total Nurses	470		490		450		430		400		370		300		177		93		80		83		78		73		65	
Total Officers	300		300		300		270		290		260		200		160		140		150		130		130		100		90	
Total Staff	3380		3410		3190		2600		2300		2020		1690		1620		1430		1320		1000		860		780		780	
Staff/Patient	0.46		0.56		0.65		0.60		0.60		0.63		0.62		0.77		0.88		1.05		0.85		0.84		0.83		0.89	



TABLE 63

DISTRIBUTION OF STAFF, SAN DIEGO - FEBRUARY 1946 - MARCH 1947

(C = civilian; M = military)

	Feb		Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		
	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	
Finance	40	10	40	8	40	14	40	28	40	31	37	33	35	22	33	14	28	19	28	16	29	17	30	18	31	16	31	14	
Disbursing	48	4	43	4	28	4	28	4	23	3	22	3	22	2	21	2	20	2	18	2	16	2	16	2	15	3	14	3	
Pers & Records	89	58	85	64	100	65	100	117	93	95	52	68	41	70	41	58	31	61	25	55	25	61	24	57	22	59	25	53	
Wel. & Rec.				1				3		3				1		1		2		2		2		6		6		6	
Commissary	406	26	396	22	378	18	352	40	336	28	293	14	285	31	260	19	242	8	212	22	182	19	187	20	182	19	180	19	
Maintenance	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	3	1	2	1	2	1	2	
Laundry	85	1	77	1	78	1	77	6	71	6	43	4	43	4	42	4	31	5	30	2	29	5	29	3	29	3	28	3	
Transportation	66	1	66	1	66	1	67	2	62	1	50	2	48	1	47	1	36	1	33	1	33	4	23	2	24	1	24	1	
Power Plant	39		35		34		27		25		18		16		15		15		15		16		16		16		16		
Fire Dept.	31		35		34		33		33		32		32		32		16		16		15		15		13		12		
Shops & Grds.	201		211		207		201		181		155		145		144		113		109		109		98		93		88		
Janitors	14		15		14		14		15		15		14		14		11		12		12		12		11		13		
Admin. Services	3	7	3	5	4	5	4	12	4	10	3	6	3	6	3	4	3	7	7	9	6	6	6	8	6	6	5	7	
Security	53	25	51	43	59	40	56	46	53	32	48	27	46	31	41	18	25	18	23	15	23	15	24	15	25	15	25	17	
Telephone	28		28		28		27	1	26	2	21	6	20	2	19	1	15	1	15	1	15	1	15	1	15	1	15	1	
Staff Qtrs.	29		34		26		23		20		18		18		16		15		14		13		12		12		13		
Library	8		8		8		9	1	5	1	5		5		5		3		3	1	4	1	3	1	3	1	3	1	
Miscellaneous	14	14	12	19	15	21	13	38	13	28	9	8	9	15	8	4	9	11	8	13	7	8	8	4	8	4	7	3	
Surg OR; CSS		30		29		28		38		31		21		24		17		15		13		15		12		13		13	
Medical		3		3		3		3		4		1		1		2		2		4		4		5		6		6	
EENT		3		2		2		7		5		3		3		2		6		8		6		8		7		5	
Dental		24		16		22		23		20		12		14		13		11		12		11		11		8		8	
Dependents	8	71	11	68	22	65	22	60	20	55	17	50	17	46	19	46	19	45	18	36	18	46	13	46	13	40	13	34	
X-Ray	1	24	1	19	1	16	1	20		15		7		14		13		14		17		12		14		14		12	
Laboratory		40		32		27		36		32		25		27		25		31		19		15		13		12		10	
Epidemiology		12		8		6		5		4		1		3		2		1		2		3		5		5		5	
Pharmacy		14		8		6		8		9		10		6		3		8		7		5		6		4		5	
Rehab & Civ Read	5	6	6	5	6	4	4	10	3	7	3	8	3	9	3	5	1	5	1	4	1	4	1	4		3		2	
Occ. Therapy		2		1		2		1		3		3		2		1		2		1		1		1		1		1	
Phys. Therapy		35		31		18		16		8		9		6		4		4		5		5		4		5		5	
Ward Corpsmen		1071		832		713		498		465		404		370		290		162		145		156		145		138		128	
Total Civilian		1157		1141		1117		1072		1005		822		785		741		613		571		537		519		508		500	
Total Enlisted		1519		1243		1120		1064		922		735		733		462		479		471		465		472		422		389	
Total Nurses		293		272		253		225		178		61		66		69		69		75		69		71		68		68	
Total Officers		299		281		279		199		181		212		177		174		129		109		105		117		108		116	
Total Staff		3270		2940		2770		2560		2290		1830		1760		1450		1290		1230		1180		1180		1110		1070	
Staff/ Patient		0.83		0.84		0.92		1.07		1.19		1.04		1.05		0.92		0.83		0.87		0.87		0.84		0.81		0.79	

TABLE 64

DISTRIBUTION OF STAFF, NEWPORT - MARCH 1946 - APRIL 1947

(C = civilian; M = military)

	Mar		Apr		May		Jun		Jul		Aug		Sep		Oct		Nov		Dec		Jan		Feb		Mar		Apr	
	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M	C	M
Finance	13	12	13	18	15	12	14	13	14	11	14	14	14	14	14	13	14	12	14	10	13	10	14	10	14	11	12	11
Disbursing	10		10		9		7		7		7		7		6		6		6		6		5		5		5	
Pers. & Records	21	39	20	38	20	34	20	21	20	17	20	19	19	18	20	19	20	18	20	17	20	12	19	12	20	12	23	12
Wel. & Rec.	1		1		1																							
Commissary	106	20	117	18	116	24	98	13	94	10	57	11	56	11	54	7	55	7	53	8	53	8	53	8	54	8	51	9
Maintenance		6		8		6		6		3		3		4		3		3		4		4		3		3		3
Laundry	18	3	19	3	20	3	15	3	14	3	14	3	14	3	14	3	13	3	8	3	9	3	9	3	9	3	9	3
Transportation	12	2	14	3	13	3	12	2	12	1	12	1	11	1	11		6		6		4		4		4		4	
Power Plant	14		14		14		14		13		13		13		13		13		10		11		11		11		10	
Shops & Grds.	33		35		35		34		33		33		33		33		24		17		21		21		21		21	
Admin. Services	2	7	2	4	1	4		4		5		5		7		8		6		6		5		7		8		8
MAA	13	24	14	20	13	23	9	13	8	9	8	12	7	11	6	10	6	10	6	7	6	5	6	5	6	5	6	5
Nurse Qtrs.	9		9		9		9		11		10		8		8		7		7		6		4		4		4	
Libraries	2	1	2	1	2	1	2	1	2	2	2	2	2	2	1	2	1	2	1	2	1	2	1	2	1	2	1	2
MOR		13		14		13		12		12		9		7		6		6		5		6		7		7		7
ECG		3		3		2		4		1		2		1		1		1		1		1		2		2		2
Cyst.		1		1		1																			1		1	
EENT		5		7		5		4		4		3		2		3		3		3		2		2		2		2
Dental		8		8		7		5		5		4		5		5		4		5		5		5		7		7
OPD- Depend.*		7		6		6		5		4		5		4		4		4		3		2		*18		18		17
Laboratory		12		12		7		6		9		8		8		8		8		7		7		8		10		10
X-Ray		8		7		7		6		7		6		6		7		7		5		4		4		5		5
Pharmacy		4		4		4		2		3		4		4		3		3		2		4		4		3		3
Phys. Therapy		5		6		4		3		4		2		3		4		1		1		2		1		2		2
Occ. Therapy		1		2		1		1		1															1		1	
Rehab & Civ Read	2	5	2	5	1	4	1	3	1	1	1	1	1		1		1		1		1		1		1		1	
Miscellaneous		10		10		7		3		7		3		5		6		4		11		10		8		7		7
Sick & Leave		11		17		25		20		4		1		3		2		2		3				3				
Ward Corpsmen		128		118		103		76		75		73		66		69		67		67		103		89		82		79
Total Civilian	257		273		267		234		229		191		185		181		167		150		152		151		154		153	
Total Enlisted	338		323		289		221		192		189		184		187		176		170		197		198		212		206	
Total Nurses	93		92		84		62		49		31		30		31		31		27		27		28		28		34	
Total Officers	57		70		49		56		45		35		36		38		40		39		38		39		32		34	
Total Staff	740		760		690		570		520		450		440		440		410		390		410		420		430		430	
Staff/Patient	0.70		0.86		0.94		0.90		0.86		0.81		0.73		0.73		0.73		0.77		0.75		0.66		0.67		0.65	



TABLE 65

## PERCENTAGE DISTRIBUTION OF TOTAL STAFF - PORTSMOUTH

ADMINISTRATIVE DIVISIONS					CLINICAL SERVICES				
<u>1946</u>	<u>Total Staff</u>	<u>Military</u>	<u>Civilian</u>	<u>Total</u>	<u>Wards</u>	<u>Other Clinical Services</u>	<u>Nurses</u>	<u>Med. Offs.</u>	<u>Total</u>
		<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>	<u>%</u>
Jan	1270	20	31	51	12	10	17	10	49
Feb	1130	17	37	54	12	8	16	10	46
Mar	1050	15	40	55	12	8	15	10	45
Apr	1000	13	42	55	13	7	15	10	45
May	940	13	42	55	14	7	13	10	44
Jun	780	12	45	57	12	7	14	10	43
Jul	700	11	47	58	10	7	14	10	42
Aug	620	14	45	59	14	8	9	10	41
Sep	590	15	46	61	14	7	7	10	39
Oct	580	15	46	61	14	7	7	10	39
Nov	570	13	48	61	14	7	7	10	39

TABLE 66

## PERCENTAGE DISTRIBUTION OF TOTAL STAFF - PHILADELPHIA

ADMINISTRATIVE DIVISIONS					CLINICAL SERVICES				
<u>1946</u>	<u>Total Staff</u>	<u>Military</u>	<u>Civilian</u>	<u>Total</u>	<u>Wards</u>	<u>Other Clinical Services</u>	<u>Nurses</u>	<u>Med.Offs.</u>	<u>Total</u>
		%	%	%	%	%	%	%	%
Jan	1910	14	29	43	14	14	19	10	57
Feb	2050	13	28	41	17	15	17	10	59
Mar	2030	12	29	41	17	17	15	10	59
Apr	1830	10	31	41	17	17	14	10	58
May	1720	10	34	44	15	17	14	10	56
Jun	1750	10	34	44	15	17	14	10	56
Jul	1650	11	34	45	20	17	10	10	56
Aug	1490	11	34	45	20	17	8	10	55
Sep	1290	11	35	46	22	17	5	10	54
Oct	1200	11	36	47	20	17	6	10	53
Nov	1100	11	37	48	19	17	6	10	52
Dec	1030	9	39	48	19	17	6	10	52
<u>1947</u>									
Jan	970	8	42	50	16	17	7	10	50



TABLE 67

## PERCENTAGE DISTRIBUTION OF TOTAL STAFF - GREAT LAKES

ADMINISTRATIVE DIVISIONS					CLINICAL SERVICES				
<u>1946</u>	<u>Total Staff</u>	<u>Military</u>	<u>Civilian</u>	<u>Total</u>	<u>Wards</u>	<u>Other Clinical Services</u>	<u>Nurses</u>	<u>Med. Offs.</u>	<u>Total</u>
		%	%	%	%	%	%	%	%
Jan	3380	26	18	44	25	8	14	9	56
Feb	3410	25	18	43	26	8	14	9	57
Mar	3190	24	20	44	24	8	14	10	58
Apr	2600	21	23	44	23	8	15	10	56
May	2300	19	26	45	18	8	17	12	55
Jun	2020	17	26	44	16	9	18	13	56
Jul	1690	18	29	47	15	8	18	12	53
Aug	1620	24	24	48	19	12	11	10	51
Sep	1430	26	24	50	20	12	8	10	50
Oct	1320	23	25	48	22	11	8	11	52
Nov	1000	21	27	48	19	11	9	13	52
Dec	860	17	31	48	15	13	9	15	52
<u>1947</u>									
Jan	780	18	34	52	14	12	9	13	48
Feb	780	20	34	54	13	12	9	12	46

TABLE 68

## PERCENTAGE DISTRIBUTION OF STAFF - SAN DIEGO

ADMINISTRATIVE DIVISIONS					CLINICAL SERVICES				
<u>1946</u>	<u>Total Staff</u>	<u>Military</u>	<u>Civilian</u>	<u>Total</u>	<u>Wards</u>	<u>Other Clinical Services</u>	<u>Nurses</u>	<u>Med.Offs.</u>	<u>Total</u>
		%	%	%	%	%	%	%	%
Jan	3550	7	32	40	33	9	10	9	60
Feb	3250	4	36	40	33	8	10	9	60
Mar	2940	6	38	44	28	8	10	10	56
Apr	2740	6	41	47	26	7	10	10	53
May	2550	12	42	54	19	9	10	8	46
Jun	2310	10	44	54	20	8	10	8	46
Jul	1900	9	43	52	21	8	8	11	48
Aug	1730	11	45	56	21	9	4	10	44
Sep	1530	9	48	57	19	9	4	11	43
Oct	1250	11	49	60	13	12	5	10	40
Nov	1170	12	49	61	12	11	6	10	39
Dec	1140	12	47	59	14	11	6	10	41
<u>1947</u>									
Jan	1120	13	46	59	13	12	6	11	41
Feb	1080	12	47	59	13	12	6	10	41
Mar	1060	12	47	59	12	11	7	11	41



TABLE 69

## PERCENTAGE DISTRIBUTION OF TOTAL STAFF - NEWPORT

ADMINISTRATIVE DIVISIONS					CLINICAL SERVICES				
1946	Total Staff	Military	Civilian	Total	Wards	Other Clinical Services	Nurses	Med.Offs.	Total
		%	%	%	%	%	%	%	%
Jan	802	20½	32	52	20	9	11	8	48
Feb	747	19	35	54	18	9	12	7	46
Mar	750	20	34	54	17	9	12	8	46
Apr	771	19	36	55	15	9	12	9	45
May	700	20	38	58	15	8	12	7	42
Jun	577	16	39	58	13	8	11	10	42
Jul	533	16	43	59	14	9	9	9	41
Aug	464	20	41	61	15	9	7	8	39
Sep	446	20	41	61	15	9	7	8	39
Oct	437	18	41	59	16	9	7	9	41
Nov	413	17	40	57	16	10	7	10	42
Dec	388	18	39	57	17	9	7	10	43
<u>1947</u>									
Jan	413	15½	36	51	25	8	7	9	49
Feb	413	15	36	51	21	12	7	9	49
Mar	412	16	36	52	20	13	7	8	48
Apr	416	16	36	52	19	13	8	8	48

TABLE 70  
MAINTENANCE DIVISION - PORTSMOUTH (VA.)  
SHOPS AND GROUNDS SECTION

<u>Date</u>	<u>Workers</u>	<u>Sq. Ft. in Use</u>	<u>Workers Per Million Sq. Ft.</u>	<u>Sq. Ft. Per Patient</u>	<u>Total Repair Requests</u>	<u>Repair Requests Per Worker</u>	<u>Repair Re- quests Per Million Sq. Ft.</u>
1946							
January	87	1,034,000	84	880	1,370	16	1,320
February	91	1,040,000	88	860	1,250	14	1,200
March	92	1,000,000	92	930	1,400	15	1,400
April	94	970,000	97	960	1,570	17	1,620
May	93	920,000	101	980	1,580	17	1,720
June	94	880,000	95	990	1,140	14	1,300
July	73	820,000	89	950	1,400	19	1,710
August	65	760,00	86	1,230	1,130	17	1,490
September	62	720,000	86	1,230	1,050	17	1,460
October	61	720,000	85	1,350	1,100	18	1,530
November	55	680,000	81	1,470	1,000	17	1,470



MAINTENANCE DIVISION - PHILADELPHIA

SHOPS AND GROUNDS SECTION

<u>Date</u>	<u>Workers</u>	<u>Sq. Ft. in Use</u>	<u>Workers Per Million Sq. Ft.</u>	<u>Sq. Ft. Per Patient</u>
1945				
January	67	800,000	84	280
February	67	810,000	83	280
March	70	820,000	85	290
April	71	830,000	85	290
May	75	840,000	89	270
June	75	850,000	88	270
July	75	860,000	87	260
August	75	860,000	87	250
September	88	860,000	102	250
October	94	860,000	109	280
November	95	860,000	110	310
December	103	860,000	119	290
1946				
January	112	860,000	130	280
February	112	850,000	132	310
March	112	840,000	133	320
April	110	830,000	133	330
May	111	820,000	135	360
June	110	810,000	136	400
July	110	800,000	138	430
August	108	790,000	137	510
September	110	780,000	141	530
October	79	770,000	103	560
November	69	760,000	91	580
December	68	750,000	91	610

TABLE 72

## MAINTENANCE DIVISION - GREAT LAKES

## SHOPS AND GROUNDS SECTION

<u>Date</u>	<u>Workers</u>	<u>Sq. Ft. In Use</u>	<u>Workers Per Million Sq. Ft.</u>	<u>Sq. Ft. Per Patient</u>	<u>Total Repair Requests</u>	<u>Repair Requests Per Worker</u>	<u>Repair Re- quests Per Million Sq. Ft.</u>
1945							
July	111	1,200,000	92	310*	1,700	15	1,420
August	103	1,200,000	86	370*	1,430	14	1,190
September	104	1,200,000	87	330*	1,310	13	1,090
October	110	1,200,000	92	310*	1,300	12	1,090
November	120	1,200,000	100	310*	1,420	12	1,180
December	121	1,200,000	101	320*	1,200	10	1,000
1946							
January	117	1,150,000	102	280*	1,560	13	1,360
February	113	1,150,000	98	360*	1,330	12	1,160
March	111	1,150,000	96	420*	1,390	13	1,210
April	102	1,100,000	93	420*	1,300	13	1,180
May	107	1,100,000	97	420*	1,090	10	990
June	85	1,050,000	82	420*	1,030	12	980
July	102	1,000,000	102	370	830	8	830
August	52	1,000,000	58	430	970	19	1,080
September	66	1,000,000	82	490	960	15	1,200
October	62	750,000	83	590	1,060	17	1,410
November	58	750,000	83	590	850	15	1,360
December	52	650,000	80	640	540	10	830
1947							
January	51	650,000	79	690	830	16	1,280
February	53	650,000	81	740	790	15	1,210

\* Corrected to patient load carried in main hospital unit.



TABLE 73

## MAINTENANCE DIVISION - SAN DIEGO

## SHOPS AND GROUNDS SECTION

<u>Date</u>	<u>Workers</u>	<u>Sq. Ft. in Use</u>	<u>Workers Per Million Sq. Ft.</u>	<u>Sq. Ft. Per Patient</u>	<u>Total Repair Requests</u>	<u>Repair Requests Per Worker</u>	<u>Repair Re- quest per Million Sq. Ft.</u>
1946							
January	207	850,000	244	200	1,747	8.5	2,050
February	203	850,000	239	220	1,599	7.9	1,880
March	213	850,000	251	240	1,612	7.6	1,900
April	209	850,000	246	270	1,582	7.6	1,860
May	203	850,000	239	350	1,490	7.4	1,750
June	183	850,000	218	440	1,301	7.1	1,550
July	157	830,000	189	470	1,070	6.8	1,290
August	147	820,000	179	490	1,098	7.5	1,340
September	146	810,000	180	510	1,114	7.7	1,370
October	115	800,000	144	520	1,503	13.0	1,880
November	112	790,000	142	560	1,211	10.8	1,530
December	113	780,000	145	580	1,109	9.8	1,420
1947							
January	101	770,000	131	540	1,378	13.6	1,790
February	96	760,000	126	550	1,186	11.3	1,580
March	91	750,000	121	550	1,090	12.0	1,450

TABLE 74  
MAINTENANCE DIVISION - NEWPORT  
SHOPS AND GROUNDS SECTION

<u>Date</u>	<u>Workers</u>	<u>Sq. Ft. in Use</u>	<u>Workers Per Million Sq. Ft.</u>	<u>Sq. Ft. Per Patient</u>	<u>Total Repair Requests</u>	<u>Repair Requests Per Worker</u>	<u>Repair Re- quests Per Million Sq. Ft.</u>
1946							
January	46	450,000	102	380	664	14.4	1,420
February	47	450,000	106	390	603	12.9	1,370
March	39	430,000	91	400	637	16.3	1,480
April	43	420,000	102	480	904	21.0	2,150
May	41	410,000	100	560	923	22.5	2,250
June	40	400,000	100	630	747	18.7	1,870
July	36	400,000	90	660	720	20.0	1,800
August	36	400,000	90	720	581	16.1	1,450
September	37	400,000	92	660	459	12.4	1,140
October	36	400,000	90	660	680	18.9	1,700
November	27	400,000	68	720	463	17.2	1,150
December	21	400,000	52	790	542	25.8	1,360
1947							
January	25	400,000	62	730	648	25.9	1,620
February	24	400,000	60	630	546	22.7	1,360
March	24	400,000	60	630	598	24.9	1,490
April	24	400,000	60	610	514	21.4	1,280



TABLE 75

## COMMISSARY DIVISION - PORTSMOUTH

<u>Date</u>	<u>*Average Daily Ration</u>	<u>Staff (Mil. &amp; Civ.)</u>	<u>Staff Per Ration</u>
1945			
April	4935	245	.049
May	4811	250	.052
June	5619	245	.042
July	5496	245	.045
August	5354	245	.046
September	4537	233	.051
October	3794	227	.060
November	2693	220	.082
December	2648	190	.072
1946			
January	2413	203	.084
February	2320	212	.091
March	2050	196	.096
April	1951	191	.098
May	1809	181	.100
June	1617	165	.102
July	1763	155	.088
August	1537	120	.078
September	1099	116	.105
October	1015	113	.111

\* Includes Hospital Corps School

TABLE 76

## COMMISSARY DIVISION - PHILADELPHIA

<u>Date</u>	<u>Average Daily Ration</u>	<u>Commissary Enlisted</u>	<u>Civilians (40hr. wk.)</u>	<u>H. C.</u>	<u>Total Staff</u>	<u>Staff Per Ration</u>	<u>Ration Per Patient</u>
1945							
January	3776	52	162	33	247	.065	
February	3780	53	182	33	268	.071	
March	3884	54	191	28	273	.070	
April	3843	54	203	26	283	.074	
May	4003	50	202	27	279	.070	
June	4060	49	200	26	275	.068	
July	4213	54	203	28	285	.068	
August	4349	50	199	37	286	.066	
September	4373	54	202	35	291	.066	
October	3841	50	235	35	320	.083	
November	3783	52	220	37	309	.082	
December	3489	48	199	36	283	.081	
1946							
January	3876	83	232	36	351	.090	1.29
February	3828	92	257	39	388	.101	1.41
March	3711	97	258	33	388	.104	1.43
April	3507	88	260	27	375	.107	1.43
May	3305	65	267	22	354	.107	1.44
June	2878	48	268	20	336	.116	1.42
July	2592	39	258	22	319	.123	1.40
August	2342	32	229	32	293	.125	1.50
September	2207	15	204	27	246	.111	1.50
October	2112	14	199	21	234	.111	1.52
November	1995	9	189	16	213	.107	1.52
December	1779	9	188	13	210	.118	1.46



TABLE 77

## COMMISSARY DIVISION - GREAT LAKES

<u>Date</u>	<u>Average Daily Rations</u>	<u>Civilians</u>	<u>Staff, Stewards Mates, etc.</u>	<u>HC</u>	<u>Total Staff</u>	<u>Staff Per Ration</u>	<u>Rations Per Patient</u>
1946							
January	9600	187	140	59	386	.040	1.29
February	8300	204	135	59	398	.048	1.35
March	7100	228	110	54	332	.055	1.44
April	6100	228	50	47	325	.053	1.40
May	5200	221	13	39	273	.052	1.35
June	4300	182		37	219	.053	1.33
July	3500	169		26	195	.056	1.28
August	2800	137		29	166	.059	1.32
September	2430	130		27	157	.065	1.50
October	2020	128		23	151	.075	1.60
November	1880	86		16	102	.054	1.60
December	1310	80		11	91	.069	1.28
1947							
January	1310	84		15	99	.076	1.39
February	1250	83		17	100	.080	1.41

TABLE 78

## COMMISSARY DIVISION - SAN DIEGO

<u>Date</u>	<u>Average Daily Rations</u>	<u>HC School</u>	<u>Hospital</u>	<u>Staff</u>	<u>Staff Per Ration</u>	<u>Rations Per Patient</u>
1946						
January	7010	1070	5940	460	.065	1.39
February	6600	1030	5570	432	.065	1.42
March	5830	800	5030	418	.072	1.44
April	5350	780	4570	396	.074	1.51
May	4650	830	3820	392	.084	1.55
June	3940	770	3170	364	.092	1.64
July	3320	490	2830	307	.093	1.61
August	2950	470	2480	316	.107	1.47
September	2570	380	2190	279	.108	1.39
October	2500	420	2080	250	.100	1.34
November	2450	410	2010	234	.097	1.42
December	2220	240	1980	201	.091	1.46
1947						
January	2220	240	1960	207	.095	1.39
February	2140	230	1910	201	.094	1.38
March	2020	240	1780	199	.099	1.32



TABLE 79  
COMMISSARY DIVISION - NEWPORT

<u>Date</u>	<u>Average Daily Rations</u>	<u>Staff</u>	<u>Staff Per Ration</u>	<u>Rations Per Patient</u>
1946				
January	1570	124	.079	1.31
February	1460	123	.084	1.30
March	1430	126	.088	1.34
April	1290	135	.105	1.46
May	1150	140	.122	1.57
June	1000	111	.111	1.57
July	890	104	.117	1.48
August	810	68	.084	1.45
September	830	67	.081	1.37
October	830	61	.074	1.37
November	780	62	.079	1.39
December	660	61	.092	1.31
1947				
January	740	61	.082	1.35
February	860	61	.071	1.36
March	870	62	.071	1.37
April	900	60	.067	1.37

TABLE 80  
MAIN OPERATING ROOM - PORTSMOUTH

<u>Date</u>	<u>Number of Operations</u>	<u>Operations Per Surgical Patient</u>	<u>Operations Per Total Patients</u>	<u>Staff - Nurses &amp; Corpsmen</u>	<u>Operations Per Staff</u>
1946					
January	162	0.41	0.14	17	9.5
February	153	0.38	0.13	16	9.6
March	137	0.38	0.13	16	8.6
April	140	0.42	0.14	15	9.3
May	136	0.44	0.15	15	9.1
June	139	0.47	0.16	14	9.9
July	157	0.57	0.18	14	11.2
August	105	0.55	0.17	9	11.7
September	85	0.48	0.15	8	10.6
October	83	0.52	0.16	8	10.4
November	82	0.59	0.18	8	10.2
Average			0.16		10.0



TABLE 81  
MAIN OPERATING ROOM - PHILADELPHIA

<u>Date</u>	<u>Number of Operations</u>	<u>Operations Per Surgical Patient</u>	<u>Operations Per Total Patients</u>	<u>Staff - Nurses &amp; Corpsmen</u>	<u>Operations Per Staff</u>
1946					
January	603	0.45	0.20	34	17.7
February	490	0.42	0.18	40	12.2
March	529	0.50	0.20	43	12.3
April	544	0.55	0.22	40	13.6
May	534	0.58	0.23	39	13.4
June	501	0.60	0.25	41	12.2
July	471	0.62	0.25	27	17.4
August	408	0.65	0.26	25	16.3
September	327	0.55	0.22	28	11.7
October	345	0.62	0.25	30	11.5
November	302	0.58	0.23	22	13.7
December	275	0.58	<u>0.23</u>	26	<u>10.6</u>
Average			0.23		13.7

TABLE 82  
MAIN OPERATING ROOM - GREAT LAKES

<u>Date</u>	<u>Number of Operations</u>	<u>Operations per Total Patients</u>	<u>Staff Nurses &amp; Corpsmen</u>	<u>Operations Per Staff</u>
1946				
January	766		68	14.2
February	653		66	12.5
March	720	0.15	60	14.6
April	674	0.15	49	16.4
May	578	0.15	49	13.8
June	557	0.17	46	12.8
July	478	0.17	31	15.4
August	309	0.15	34	9.1
September	243	0.15	27	9.0
October	259	0.21	22	11.8
November	218	0.19	17	12.8
December	124		18	
1947				
January	142	0.15	14	10.1
February	137	0.16	13	10.5
Average		0.16		12.5



TABLE 83  
MAIN OPERATING ROOM - SAN DIEGO

<u>Date</u>	<u>Number of Operations</u>	<u>Operations Per Surgical Patient</u>	<u>Operations Per Total Patients</u>	<u>Staff - Nurses &amp; Corpsmen</u>	<u>Operations Per Staff</u>
1946					
January	588		.14	60	9.8
February	525		.13	35	15.0
March	538		.15	35	15.4
April	508		.17	34	14.9
May	519		.22	42	12.3
June	386	.51	.20	34	11.4
July	385	.63	.22	22	17.5
August	362	.59	.21	24	15.7
September	315	.61	.20	16	19.7
October	342	.71	.22	16	21.4
November	261	.59	.18	13	20.1
December	228	.56	.17	16	14.3
1947					
January	259	.59	.18	11	23.5
February	309	.74	.22	12	25.8
March	288	.69	.21	14	20.6
12-Month Average			0.20		18.1

TABLE 84  
MAIN OPERATING ROOM - NEWPORT

<u>Date</u>	<u>Number of Operations</u>	<u>Operations per Total Patients</u>	<u>Staff Nurses &amp; Corpsmen</u>	<u>Operations Per Staff</u>
1946				
July	124	.21	13	9.6
August	145	.26	10	14.5
September	138	.23	8	17.2
October	153	.25	7	21.9
November	139	.24	7	19.9
December	98	.19	6	16.3
1947				
January	128	.23	7	18.3
February	148	.23	8	18.5
March	186	.29	8	23.2
April	194	.29	8	24.2
Average		.24		18.4



TABLE 85  
DENTAL SERVICE - PORTSMOUTH

<u>Date</u>	<u>Sittings (Approximate)</u>	<u>Enlisted Staff</u>	<u>Sittings Per Enlisted Staff</u>	<u>Sittings Per Patient</u>
1946				
January	2560	27	95	2.16
February	1760	18	98	1.47
March	1600	13	123	1.49
April	1120	14	80	1.02
May	740	12	62	.79
June	790	5	158	.72
July	460	9	51	.53
August	360	9	40	.57
September	400	7	57	.68
October	370	7	53	.69
November	310	6	52	.68
Average				0.98

TABLE 86  
DENTAL SERVICE - PHILADELPHIA

<u>Date</u>	<u>Total Sittings</u>	<u>Dental Officers</u>	<u>Sittings Per Dental Officer</u>	<u>Enlisted Staff</u>	<u>Sittings Per Enlisted Staff</u>	<u>Sittings Per Patient</u>
<u>1945</u>						
Jan	1198	7	171	14	86	.42
Feb	1300	5	260	14	93	.46
Mar	1386	5	277	16	87	.47
Apr	1541	5	308	16	96	.53
May	1484	6	247	17	87	.48
Jun	1523	6	254	18	85	.50
Jul	1374	7	196	16	85	.44
Aug	1408	7	201	16	88	.42
Sep	1526	6	254	20	76	.44
Oct	1759	8	220	15	117	.57
Nov	2339	8	292	11	213	.84
Dec	1977	10	198	9	220	.67
<u>1946</u>						
Jan	2016	9	224	10	202	.66
Feb	1701	8.5	200	17	100	.62
Mar	1515	7	216	18	84	.58
Apr	1949	9	217	18	108	.79
May	2005	10	200	21	95	.88
Jun	1737	11	158	15	116	.86
Jul	1665	11	155	13	128	.90
Aug	1408	9	156	15	94	.90
Sep	1188	7	170		79	.81
Oct	1279	6	213	15	85	.93
Nov	1085	6	181	14	78	.83
Dec	1268	6	211	14	91	1.04
Average 1946						0.82



TABLE 87  
DENTAL SERVICE - GREAT LAKES

<u>Date</u>	<u>Total Sittings</u>	<u>Dental Officers</u>	<u>Sittings Per Dental Officer</u>	<u>Enlisted Staff</u>	<u>Sittings Per Enlisted Staff</u>	<u>Sittings Per Patient</u>
<u>1945</u>						
Jul	2138	10	214	17	126	.56
Aug	1872	11	170	17	110	.57
Sep	1865	10	186	17	110	.51
Oct	1799	12	160	18	100	.46
Nov	1730	11	157	18	96	.44
Dec	1239	10	123	11	113	.33
<u>1946</u>						
Jan	1736	8	217	9	158	.41
Feb	2114	12	176	17	124	.66
Mar	1288	7	184	11	117	.46
Apr	1079	8	135	7	154	.40
May	743	8	93	9	83	.27
Jun	834	9	93	11	76	.32
Jul	804	9	89	8	100	.29
Aug	1073	8	134	17	63	.51
Sep	817	5	163	16	51	.51
Oct	555	3	185	11	50	.44
Nov	701	4	175	12	58	.60
Dec	634	4	158	9	70	.62
<u>1947</u>						
Jan	453	4	113	5	91	.48
Average 1946						0.46

TABLE 88  
DENTAL SERVICE - SAN DIEGO

<u>Date</u>	<u>Total Sittings</u>	<u>Dental Officers</u>	<u>Sittings Per Dental Officer</u>	<u>Enlisted Staff</u>	<u>Sittings Per Enlisted Staff</u>	<u>Sittings Per Patient</u>
<u>1945</u>						
Apr	6758	23	294	44	154	
May	6457	20	322	43	153	
Jun	6223	22	283	44	142	
Jul	7244	25	289	43	168	
Aug	6780	23	294	41	165	
Sep	6102	25	244	42	145	
Oct	6770	24	282	33	205	
Nov	6034	23	262	25	241	
Dec	4578	24	191	21	190	
<u>1946</u>						
Jan	4312	17	254	22	196	1.01
Feb	3350	15	223	20	168	.85
Mar	3395	14	242	17	199	.97
Apr	3381	13	260	22	154	1.12
May	3408	14	243	20	170	1.42
Jun	2150	13	165	17	126	1.11
Jul	2269	9	252	13	175	1.29
Aug	1843	8	231	12	153	1.10
Sep	1966	8	246	11	179	1.25
Oct	2203	9	245	10	220	1.42
Nov	1928	8	241	10	193	1.36
Dec	1858	8	230	10	184	1.36
<u>1947</u>						
Jan	2005	8	251	11	182	1.42
Feb	1710	7	245	9	190	1.24
Mar	1632	7	234	8	204	1.20
Average						1.21



TABLE 89  
DENTAL SERVICE - NEWPORT

<u>Date</u>	<u>Total Sittings</u>	<u>Enlisted Staff</u>	<u>Sittings Per Enlisted Staff</u>	<u>Sittings Per Patient</u>
<u>1946</u>				
January	947	9	105	.79
February	759	8	95	.68
March	882	8	110	.83
April	858	8	107	.97
May	774	7	111	1.05
June	632	5	126	1.00
July	820	5	164	1.36
August	732	4	183	1.31
September	670	5	134	1.10
October	708	5	142	1.17
November	324	5	65	.58
December	547	5	109	1.08
<u>1947</u>				
January	497	5	99	.91
February	467	5	93	.74
March	538	7	77	.85
April	760	7	109	1.15
May	350	7	50	.57
Average				0.95

TABLE 90

## EENT SERVICE - PORTSMOUTH

<u>Date 1945</u>	<u>Medical Officers</u>	<u>Total Visits</u>	<u>Total Visits Per Patient</u>	<u>EENT Staff*</u>	<u>Visits Per Staff</u>
September	5	1,922	.84	8	240
October	5	2,089	1.11	8	260
November	6	1,482	1.07	8	190
December	6	780	-	8	-
1946					
January	4	1,087	.92	8	140
February	5	1,306	1.09	7	190
March	5	814	.76	7	120
April	5	1,028	1.02	8	130
May	5	1,212	1.30	7	170
June	4	789	.89	5	160
July	4	741	.86	6	120
August	3	661	1.07	5	130
September	3	482	.82	5	100
October	2	521	.98	5	100
November	2	463	1.00	5	90

\* EENT staff includes the EENT clinic and operating rooms, but does not, include ward corpsmen assigned to EENT wards or medical officers.



TABLE 91  
EENT SERVICE - PHILADELPHIA

<u>Date 1945</u>	<u>Total Visits(except Spectacle Dispensing)</u>	<u>VOP Visits</u>	<u>Total Hosp. Visits</u>	<u>Visits Per Patient</u>	<u>EENT Staff*</u>	<u>Visits Per Staff</u>
January	3,402	306	3,096	1.09	17	200
February	3,162	273	2,889	1.01	17	186
March	3,178	306	2,872	.97	16	199
April	3,142	310	2,824	.92	16	196
May	3,300	317	3,023	.99	19	176
June	3,268	250	3,018	.96	23	142
July	3,873	188	3,685	1.11	24	161
August	3,948	274	3,664	1.05	21	188
September	3,915	383	3,532	1.01	26	146
October	4,397	512	3,885	1.26	28	157
November	4,054	626	3,428	1.23	31	131
December	2,529	478	(2,051)		29	-
1946						
January	3,652	643	3,009	.99	26	140
February	3,544	613	2,931	1.08	25	142
March	3,618	1,039	2,579	.99	29	125
April	3,703	1,031	2,672	1.09	28	132
May	3,972	1,114	2,858	1.25	29	137
June	2,867	894	1,973	.98	29	99
July	2,879	834	2,045	1.10	31	93
August	3,366	1,185	2,181	1.40	33	102
September	2,989	1,444	1,545	1.06	22	136
October	3,015	1,258	1,760	1.28	20	158
November	2,430	1,041	1,390	1.06	18	138
December	2,484	998	1,480	1.21	16	155

\* EENT staff includes the EENT clinic and operating rooms, but does not include ward corpsmen assigned to EENT wards or medical officers.

TABLE 92  
EENT SERVICE - SAN DIEGO

Date 1946	Total Visits	Visits Per Patient	EENT Staff*	Visits Per Staff
January	2,942	.69		
February	1,890	.48		
March	2,428	.70		
April	2,099	.70		
May	1,832	.77	7	260
June	1,229	.64	5	250
July	1,054	.60	3	350
August	1,475	.88	-	-
September	1,423	.91	-	-
October	1,612	1.04	6	270
November	1,590	1.12	8	200
December	1,206	.89	6	200
1947				
January	1,414	1.00	8	180
February	1,316	.95	7	190
March	1,795	1.32	5	330
April	1,919	1.42	6	320

\* EENT staff includes the EENT clinic and operating rooms, but does not include ward corpsmen assigned to EENT wards or medical officers.



TABLE 93  
EENT SERVICE - NEWPORT

<u>Date</u> <u>1946</u>	<u>Total Visits</u>	<u>Visits Per Patient</u>	<u>EENT Staff*</u>	<u>Visits Per Staff</u>
January	1,930	1.6	7	280
February	2,180	1.8	6	360
March	1,630	1.5	6	270
April	2,430	2.8	8	300
May	2,090	2.9	6	350
June	1,600	2.5	5	320
July	1,140	1.9	5	230
August	773	1.4	4	190
September	408	.7	3	140
October	701	1.2	4	180
November	1,050	1.9	4	210
December	616	1.2	4	150
1947				
January	673	1.2	3	220
February	676	1.1	3	230
March	609	1.0	3	200
April	728	1.1	3	240

\*EENT staff includes the EENT clinic and operating rooms, but does not include ward corpsmen assigned to EENT wards or medical officers.

TABLE 94  
X-RAY SERVICE - PORTSMOUTH

<u>Date</u>	<u>Total X-ray Exams</u>	<u>X-rays Per Patient</u>	<u>Corpsmen</u>	<u>X-rays Per Staff</u>
1945				
August	3022	1.03		
September	2285	.99	15	152
October	1703	.91	10	170
November	1428	1.03	9	159
December	925	.75	8	116
1946				
January	1318	1.12	7	188
February	1053	.88	7	150
March	1171	1.09	7	167
April	1133	1.13	6	190
May	1215	1.30	4	304
June	1090	1.23	3	363
July	847	.98	4	212
August	705	1.14	6	117
September	606	1.03	6	101
October	588	1.10	6	98
November	476	1.05	6	79



TABLE 95

## X-RAY SERVICE - PHILADELPHIA

<u>Date</u>	<u>Total X-ray Exams</u>	<u>Total VOP X-ray Exams</u>	<u>Total Hospital X-rays</u>	<u>Hospital X-rays Per Patient</u>	<u>Corpsmen</u>	<u>X-rays Per Staff</u>
1946						
January	3164	877	2277	.75	16	198
February	2584	738	1846	.68	22	117
March	3516	1518	1998	.77	21	167
April	3968	1657	2311	.95	19	209
May	3478	1248	2230	.98	25	139
June	2855	1087	1768	.88	23	124
July	2991	1115	1884	1.02	22	136
August	2642	1055	1597	1.02	21	126
September	2350	1010	1340	.92	18	131
October	3092	1284	1808	1.31	20	155
November	2558	1303	1255	.96	21	122
December	2462	960	1502	1.22	17	144
1947						
January	2681	1232	1449	1.18	17	158

TABLE 96

## X-RAY SERVICE - GREAT LAKES

<u>Date</u>	<u>Total X-ray Exams</u>	<u>X-rays Per Patient</u>	<u>Corpsmen</u>	<u>X-rays Per Staff</u>
1946				
January	6483	.88	24	270
February	4627	.76	20	231
March	4258	.86	25	170
April	3976	.91	25	159
May	3270	.85	14	234
June	2431	.76	23	106
July	2278	.83	14	163
August	1883	.89	21	90
September	1402	.87	19	74
October	1187	.94	17	70
November	1197	1.02	13	92
December	943	.92	11	86
1947				
January	1012	1.07	11	92
February	969	1.10	11	88



TABLE 97  
X-RAY SERVICE - SAN DIEGO

<u>Date</u>	<u>Outpatient Dependents</u>	<u>Total X-ray Exams</u>	<u>X-rays Per Patient</u>	<u>Corpsmen</u>	<u>X-rays Per Staff</u>
1946					
January	927	4382	.99	31	141
February	450	3345	.85	24	140
March	483	3236		19	170
April	540	3542		16	221
May	694	3287		20	164
June	523	3296		15	220
July	470	2779		7	397
August	498	2915		14	208
September	498	2729		13	210
October	477	2672		14	191
November	428	2172		17	128
December	622	2332		12	194
1947					
January	642	2548		14	182
February	470	2190		14	156
March	592	2260		12	188

TABLE 98  
X-RAY SERVICE - NEWPORT

<u>Date</u>	<u>Total X-ray Exams</u>	<u>Chest X-rays</u>	<u>X-rays Per Patient</u>	<u>Corpsmen</u>	<u>X-rays Per Staff</u>
1946					
January	1207	531	1.0	6	20
February	923	333	0.8	6	150
March	1056	185	1.0	8	132
April	1111	424	1.3	7	159
May	1079	267	1.5	7	154
June	786	212	1.2	6	131
July	998	366	1.6	7	143
August	915	262	1.6	6	152
September	1003	305	1.6	6	167
October	1168	364	1.9	7	167
November	953	405	1.7	7	136
December	881	412	1.7	5	176
1947					
January	1037	366	1.9	4	259
February	815	276	1.3	4	204
March	1075	437	1.7	5	215
April	1189	534	1.8	5	238



TABLE 99

## LABORATORY SERVICE - PORTSMOUTH (VA.)

<u>Date</u>	<u>Number of Tests</u>	<u>Staff Corpsmen</u>	<u>Test Per Patient</u>	<u>Test Per Staff</u>
<u>1945</u>				
April	24,729	40	9.6	620
May	24,284	43	10.2	560
June	25,575	37	8.2	690
July	21,635	45	7.6	480
August	21,403	49	7.3	440
September	18,643	37	8.1	510
October	17,460	34	9.3	510
November	13,801	29	9.9	480
December	10,317	26	8.4	400
1946				
January	12,354	16	8.4	770
February	11,440	12	9.7	955
March	12,776	10	11.9	1,280
April	11,580	9	11.5	1,380
May	10,547	11	11.3	960
June	9,983	9	11.3	1,110
July	7,401	9	8.6	825
August	6,178	8	10.0	770
September	4,911	8	8.4	615
October	5,320	7	10.0	760
November	4,379	6	9.7	730
Average for 1946			10.3	925

TABLE 100

## LABORATORY SERVICE - PHILADELPHIA

Date 1945	Total Staff	Number of Examinations			Exams per * Patient (Exc. VOP)	Total Exams * per Total Staff
		Main Lab.	O.P.D.	V.O.P.		
January	48	20,799	1,653	1,611	7.9	500
February	43	17,583	1,584	1,553	6.8	480
March	48	20,250	2,210	1,371	7.6	500
April	45	18,436	1,711	934	6.9	470
May	50	19,248	2,245	1,124	7.0	450
June	49	19,201	1,609	957	6.6	440
July	47	21,739	1,338	1,858	6.9	530
August	50	19,478	1,809	1,831	6.1	460
September	49	20,485	1,809	1,863	6.4	490
October	51	23,935	4,926	2,413	9.4	610
November	55	24,390	1,158	2,822	9.1	520
December	49	18,444	1,073	2,275	6.6	420
1946						
January	36	23,593	897	2,102	8.1	740
February	34	17,773	827	1,049	6.8	580
March	41	17,945	1,763	1,836	7.5	530
April	42	16,674	2,483	2,524	7.8	520
May	36	17,735	2,348	1,913	8.7	610
June	39	15,585	3,948	1,724	9.6	550
July	40	15,144	1,562	1,492	8.9	460
August	36	14,603	1,381	1,808	10.3	470
Sept	26	11,200	902	1,219	8.3	510
October	24	12,156	1,433	1,251	9.8	620
November	22	9,220	1,319	1,268	8.0	540
December	24	9,742	1,028	2,560	8.8	530
Average for 1946					8.8	555

\* In calculating expectancy, V.O.P. tests were not included. In calculating performance per staff member, V.O.P. tests were included.



TABLE 101  
LABORATORY SERVICE - GREAT LAKES

<u>Date</u>	<u>Total Tests</u>	<u>Tests per Patient</u>	<u>Staff Corpsmen</u>	<u>Tests per Staff</u>
1946				
January	60,022	8.1	49	1,220
February	54,609	8.9	54	1,010
March	58,251	11.8	53	1,100
April	53,854	12.4	42	2,180
May	43,851	11.4	33	1,330
June	32,516	10.1	25	1,300
July	17,981	6.6	17	1,080
August	11,589	5.5	20	580
September	9,084	5.6	18	500
October	8,840	7.0	14	630
November	8,259	7.0	12	690
December	7,550	7.6	12	630
1947				
January	7,416	7.9	12	620
February	7,142	8.1	12	600
Average		8.4		980

TABLE 102  
LABORATORY SERVICE - SAN DIEGO

<u>Date</u>	<u>Total Tests</u>	<u>Tests per Patient</u>	<u>Staff Corpsmen</u>	<u>Exams per Staff</u>
1946				
January	27,283	6.4	54	506
February	22,113	5.6	40	553
March	19,066	5.5	32	596
April	20,632	6.8	27	766
May	19,770	8.2	36	550
June	15,543	8.1	32	486
July	6,880	3.9	25	275
August	6,760	4.0	27	250
September	6,680	4.2	25	267
October	8,510	5.5	31	275
November	8,960	6.3	19	472
December	6,400	4.7	15	427
1947				
January	6,950	4.9	13	535
February	7,648	5.5	12	637
March	7,750	5.7	10	775
Average		5.7		490



TABLE 103  
LABORATORY SERVICE - NEWPORT

<u>Date</u>	<u>Total Exams</u>	<u>Exams per Patient</u>	<u>Staff Corpsmen</u>	<u>Exams per Staff</u>
1946				
January	10,842	9.0	15	723
February	8,124	7.3	15	580
March	7,765	7.3	12	647
April	8,824	10.0	12	735
May	7,915	10.8	7	1,131
June	7,038	11.1	6	1,173
July	7,902	13.1	9	988
August	7,672	13.7	8	959
September	7,181	11.8	8	895
October	6,882	11.2	8	860
November	7,221	12.8	8	903
December	6,824	13.5	7	975
1947				
January	5,943	10.8	7	849
February	4,756	7.5	8	594
March	6,558	10.3	10	646
April	7,585	11.5	10	758
Average		10.7		840

TABLE 104

## NURSES AT PORTSMOUTH - 1946

Department	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wards & S.O.Q.	123	101	91	80	53	55	48	24	19	21	22	20
Dependents Unit	52	44	32	32	27	28	31	22	15	14	14	13
M. C. R.	10	9	7	7	6	6	6	4	1	1	1	1
Diet Kitchen	5	5	5	5	5	2	3	2	2	2	2	2
E.E.N.T.	4	3	3	3	2	2	2	1	1	1	1	1
Central Surgical Supply	8	7	5	5	5	1						
Linen	3	2	1	2	1	1	2	2				
Physiotherapy	1	1	1	1	1	1						
Chief Nurse	6	6	6	5	2	2	2	2	2	2	2	2
Nurse Quarters	6	5	4	3	1	1	1					
Miscellaneous	13	7	5	4	4	4						
Leave, Sick	<u>7</u>	<u>15</u>	<u>8</u>	<u>7</u>	<u>9</u>	<u>2</u>	<u>5</u>	<u>2</u>	<u>1</u>	<u>2</u>	<u>2</u>	<u>1</u>
Total	246	208	178	157	130	115	109	59	41	43	44	40
Patients per nurse	4.8	5.9	6.1	6.4	7.2	7.7	7.9	10.5	14.3	12.4	10.2	11.5
Number of Wards	33	29	29	27	22	22	18	10	9	9	9	9
Ward Nurses Per Ward	3.7	3.5	3.1	3.0	2.4	2.5	2.7	2.4	2.1	2.3	2.4	2.2



TABLE 105

## NURSES AT PHILADELPHIA - 1946

Department	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Wards and S.O.Q.	245	238	224	193	167	156	126	68	46	45	42	45
Dependents Unit	8	8	23	23	27	27	26	26	18	17	16	16
M.O.R.	8	9	11	10	12	9	7	6	2	2	2	2
Diet Kitchen	10	11	8	10	8	6	4	2	2	2	2	2
E.E.N.T.	6	6	5	5	5	5	4	4	1	1	1	1
Central Surgical Supply	15	14	14	12	11	9	4	3	1	1	1	1
Linen	3	4	4	3	3	3	1	1	1	1	1	1
Physiotherapy	1	2	2	2	2	2	1	1	1	1	1	1
Chief Nurse	5	5	5	5	6	5	4	3	2	3	2	2
Nurse Quarters	3	3	4	4	3	3	3	2	1	1	1	1
Miscellaneous	41	39	7	6	5	5	4	2	1	1	1	1
Leave, Sick	<u>17</u>	<u>18</u>	<u>16</u>	<u>13</u>	<u>9</u>	<u>22</u>	<u>6</u>	<u>8</u>	<u>0</u>	<u>6</u>	<u>5</u>	<u>3</u>
Total	362	361	323	286	258	252	190	126	76	81	75	76
Patient Per Nurse	8.4	7.5	8.0	8.5	8.8	8.1	10.9	12.3	20.3	18.0	17.9	16.9
Active Wards	47	47	46	46	46	44	40	35	34	33	32	32
Ward Nurses Per Ward	5.2	5.1	4.9	4.2	3.6	3.5	3.1	1.9	1.4	1.4	1.3	1.4

TABLE 106

## NURSES AT GREAT LAKES - JANUARY 1946 - MARCH 1947

Department	1946												1947		
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Wards	237	235	204	200	172	170	185	102	47	38	40	36	32	30	28
Operating Room	15	16	16	15	15	12	10	8	4	4	5	4	3	3	3
Central Supply	5	5	5	5	4	4	4	4	1	1	2	1	1	1	1
E.E.N.T.	4	5	4	4	4	4	4	2	1	1	2	1	1	1	1
Diet Kitchen	5	5	5	6	6	6	6	6	4	4	4	4	2	2	2
Linen Room	4	4	4	4	3	4	2	1	1	1	1	1	1	1	1
Other	5	5	5	6	5	5	4	2	2	2	2	2	2	1	1
Chief Nurse	16	17	15	16	14	13	12	10	6	5	5	4	3	3	2
Nurses Quarters	8	7	8	7	8	7	7	3	1	1	1	1	1	1	1
Leave, Sick	13	23	23	22	26	28	28	11	9	7	5	8	11	7	2
Dependents Service	<u>37</u>	<u>36</u>	<u>35</u>	<u>37</u>	<u>37</u>	<u>36</u>	<u>34</u>	<u>27</u>	<u>17</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>16</u>	<u>15</u>	<u>17</u>
Total on Duty at Main Hospital	349	348	320	307	295	288	298	177	93	80	83	78	73	65	62
(Main Hosp) Patients per Nurse	12.0	9.2	8.8	8.8	9.1	9.0	9.2	11.9	17.4	15.7	14.2	13.1	12.0	13.6	
Main Hosp. Number of Wards	70	70	70	70	70	70	69	51	47	40	22	20	26	25	25
Main Hosp-Ward Nurses per Ward	3.4	3.4	2.9	2.8	2.4	2.4	2.7	2.0	1.0	1.0	1.2	1.2	1.2	1.2	1.1



TABLE 107

NURSES AT SAN DIEGO - AUGUST 1946 - MARCH 1947

Department	1946					1947		
	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Dependents Service	30	34	32	32	30	30	30	30
Out-Patient Department	5	3	3	3	3	2	2	2
Surgery	1	1	2	2	3	3	3	3
S.O.Q.	3	3	5	7	8	8	8	7
Wards	14	13	16	14	21	18	20	16
Central Supply	1	1	1	1	1	1	1	1
Admission Ward	1	1	1	1	1	1	1	1
Linen Room	0	0	0	1	1	1	1	1
Diet Kitchen	2	2	2	2	2	2	2	2
Chief Nurse's Office	3	2	3	2	3	3	3	3
Leave, Sick	<u>1</u>	<u>4</u>	<u>4</u>	<u>3</u>	<u>3</u>	<u>1</u>	<u>2</u>	<u>4</u>
Total	61	63	69	69	76	70	73	70
Patients per Nurse	27.6	24.2	22.5	20.5	17.8	19.7	18.9	19.4
Number of Wards (Corrected for S.O.Q.)	34	32	29	28	28	28	28	28
Ward Nurses per Ward	0.6	0.6	0.8	0.8	1.1	1.0	1.1	0.9

TABLE 108

NURSES AT NEWPORT - JANUARY 1946 - MAY 1947

Department	1946												1947				
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Wards and S.C.Q.	56	59	69	66	60	47	34	19	20	22	22	22	17	15	15	19	21
Chief Nurse	4	4	4	5	5	4	2	1	1	1	1	1	1	1	1	1	1
M.C.R.	2	3	3	3	3	3	2	2	2	2	2	2	2	2	2	1	1
Anesthesia	1	1	1	1	1	1											
E.E.N.T.	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1
Diet Kitchen	2	2	3	4	4	4	4	2	2	2	2	2	1	2	2	2	2
Linen Room (and Classes)	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1
O.P.D.	2	2	2	2	3	2	2	1	1	1	1	1	1	1	1	1	1
Dependents													2	5	5	5	10
Nurse Quarters	2	2	2	2	2	1	1										
X-ray	1	1	2	1	1												
Special Duty (SOQ)	3																
Physiotherapy					1	1	1	1									1
Leave, Sick	<u>4</u>	<u>5</u>	<u>5</u>	<u>3</u>	<u>3</u>	<u>4</u>	<u>2</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>1</u>	<u>1</u>	—	—	<u>1</u>	—	—
Total	79	81	93	90	86	69	50	30	31	34	31	31	26	28	29	32	40
Patients per Nurse	15.2	13.8	11.4	9.8	8.5	9.2	12.0	18.6	19.6	17.8	18.1	16.3	21.1	22.6	22.0	20.6	15.5
Ward Nurses per Ward	2.8	2.2	2.6	2.5	2.4	1.9	1.4	0.9	1.0	1.1	1.2	1.2	1.2	0.7	0.8	0.9	1.0



TABLE 109

## DISTRIBUTION OF STAFF CORPSMEN - PORTSMOUTH

<u>Date</u> <u>1946</u>	<u>Total</u> <u>Ward</u> <u>Corpsmen</u>	<u>Patients</u> <u>Per Ward</u> <u>Corpsmen</u>	<u>Ward</u> <u>Corpsmen</u> <u>Per Ward</u>	<u>Total</u> <u>Corpsmen</u>	<u>% On</u> <u>Wards</u>	<u>%</u> <u>Clinical</u> <u>Service</u>	<u>%</u> <u>Admin.</u> <u>Service</u>
January	160	7.4	4.8	550	29	23	48
February	142	8.5	4.9	430	33	21	46
March	136	7.9	4.7	380	36	22	42
April	140	7.2	5.2	350	40	21	39
May	154	6.0	7.0	350	44	19	37
June	97	9.1	4.4	250	40	20	40
July	77	11.2	4.3	210	38	23	39
August	94	6.6	9.4	230	41	21	38
September	86	6.8	9.5	220	40	19	41
October	85	6.3	9.4	220	41	19	40
November	82	5.6	9.1	210	44	19	37

TABLE 110

## DISTRIBUTION OF STAFF CORPSMEN - PHILADELPHIA

<u>Date</u> <u>1946</u>	<u>Total</u> <u>Ward</u> <u>Corpsmen</u>	<u>Patients</u> <u>Per Ward</u> <u>Corpsmen</u>	<u>Ward</u> <u>Corpsmen</u> <u>Per Ward</u>	<u>Total</u> <u>Corpsmen</u>	<u>% On</u> <u>Wards</u>	<u>%</u> <u>Clinical</u> <u>Service</u>	<u>%</u> <u>Admin.</u> <u>Service</u>
January	330	9.2	6.8	970	34	34	32
February	400	6.8	8.3	1,080	37	34	29
March	380	6.8	8.0	1,000	38	38	24
April	335	7.3	7.1	880	38	39	23
May	285	8.0	6.0	800	36	39	24
June	310	6.5	6.7	880	35	40	25
July	360	5.2	8.6	850	43	34	23
August	340	4.6	8.9	800	43	34	23
September	330	4.4	9.1	750	44	34	22
October	275	5.0	7.7	690	40	34	25
November	250	5.2	7.2	600	42	35	23
December	230	5.3	6.6	530	43	37	20
1947							
January				458	39	41	20
February				415	40	40	20



TABLE 111

## DISTRIBUTION OF STAFF CORPSMEN - GREAT LAKES

<u>Date</u> <u>1946</u>	<u>Total</u> <u>Ward</u> <u>Corpsmen</u>	<u>Patients</u> <u>Per Ward</u> <u>Corpsmen</u>	<u>Ward</u> <u>Corpsmen</u> <u>Per Ward</u>	<u>Total</u> <u>Corpsmen</u>	<u>% On</u> <u>Wards</u>	<u>%</u> <u>Clinical</u> <u>Service</u>	<u>%</u> <u>Admin.</u> <u>Service</u>
February	808	9.2	7.1	1,650	49	14	37
March	824	7.4	7.4	1,720	48	14	38
April	745	6.6	7.2	1,550	48	14	38
May	552	7.9	5.6	1,280	43	16	41
June	390	9.9	4.7	970	40	19	41
July	327	9.8	5.1	800	41	17	42
August	284	9.6	5.4	750	38	19	43
September	329	6.4	6.6	860	38	18	44
October	276	5.9	6.6	660	42	17	40
November	272	4.6	8.2	650	42	18	40
December	142	8.3	4.9	360	40	24	36
1947							
January	130	7.9	5.2	360	36	21	43
February	105	9.0	4.2	270	39	21	40
March	101	8.8	4.0				

TABLE 112

## DISTRIBUTION OF STAFF CORPSMEN - SAN DIEGO

Date 1946	Total Ward Corpsmen	Patients Per Ward Corpsmen	Ward Corpsmen Per Ward	Total Corpsmen	% On Wards	% Clinical Service	% Admin. Service
January	1,155	3.7		1,760	68	18	14
February	1,067	3.7		1,520	72	18	10
March	832	4.2		1,240	68	18	14
April	713	4.3		1,120	66	18	15
May	493	4.9		1,060	48	23	29
June	465	4.2		920	52	22	26
July	404	4.4		740	56	21	23
August	370	4.6	10.9	730	52	22	26
September	290	5.4	9.1	460	53	24	23
October	161	9.6	5.3	480	36	33	31
November	145	9.8	4.8	470	35	32	33
December	156	8.8	5.2	470	37	30	33
1947							
January	145	9.8	4.8	470	35	32	33
February	137	10.1	4.6	420	35	32	33
March	127	10.7	4.2	390	34	32	34



TABLE 113

## DISTRIBUTION OF STAFF CORPSMEN - NEWPORT

<u>Date</u> <u>1946</u>	<u>Total</u> <u>Ward</u> <u>Corpsmen</u>	<u>Patients</u> <u>Per Ward</u> <u>Corpsmen</u>	<u>Ward</u> <u>Corpsmen</u> <u>Per Ward</u>	<u>Total</u> <u>Corpsmen</u>	<u>% On</u> <u>Wards</u>	<u>%</u> <u>Clinical</u> <u>Service</u>	<u>%</u> <u>Admin.</u> <u>Service</u>
January	162	7.4	6.0	380	43	17	40
February	135	8.3	5.0	324	42	20	38
March	128	8.3	4.9	324	39	21	40
April	118	7.5	4.7	317	37	22	41
May	103	7.1	4.1	282	37	20	43
June	76	8.4	3.2	206	37	23	40
July	75	8.0	3.6	193	39	25	36
August	73	7.7	3.5	191	38	23	39
September	66	9.2	3.3	182	36	22	42
October	69	8.8	3.6	180	38	23	39
November	67	8.4	3.7	173	39	24	37
December	67	7.5	4.8	167	40	20	40
1947							
January	103	5.3	4.9	195	53	17	30
February	89	7.1	4.4	194	46	25	29
March	82	7.8	3.9	195	42	27	31
April	79	8.3	3.8	192	41	27	32

TABLE 114  
DEPENDENTS SERVICE - PORTSMOUTH

<u>Date</u>	<u>Staff</u>				<u>Average In- Patient</u>	<u>Out- Patient Visits</u>	<u>Staff Per In- Patient</u>
	<u>Medical Officers</u>	<u>Nurses</u>	<u>Enlisted &amp; Civilians</u>	<u>Total</u>			
1946							
January	10	45	38	93	43	2321	2.16
February	10	39	42	91	43	1835	2.12
March	9	33	36	78	45	1732	1.73
April	13	32	37	82	49	1949	1.67
May	14	34	35	83	43	1840	1.93
June	14	31	28	73	33	2004	2.21
July	11	20	21	52	33	2101	1.57
August	12	15	25	52	38	2145	1.37
September	10	15	27	52	24	1876	2.16
October	8	13	23	44	30	2456	1.46
November	8	13	22	43	26	2188	1.65



TABLE 115  
DEPENDENTS SERVICE - PHILADELPHIA

<u>Date</u>	<u>Staff</u>				<u>Average In- Patient</u>	<u>Out- Patient Visits</u>	<u>Staff Per In- Patient</u>
	<u>Medical Officers</u>	<u>Nurses</u>	<u>Enlisted &amp; Civilians</u>	<u>Total</u>			
1946							
January	6	8	12	26	6	2194	
February	7	8	39	54	34	1844	1.6
March	8	23	46	77	56	2300	1.4
April	8	23	41	72	52	2501	1.4
May	8	27	45	80	57	3046	1.4
June	8	27	43	78	43	2798	1.8
July	7	26	60	93	40	2441	2.3
August	6	26	42	74	38	2430	1.9
September	6	18	25	49	35	2181	1.4
October	6	17	28	51	34	2622	1.5
November	6	16	24	46	32	2329	1.4
December	6	16	26	48	47	2371	1.0
1947							
January	6	16	30	52	66		0.8
February	6	16	28	50	63		0.8

TABLE 116

## DEPENDENTS SERVICE - GREAT LAKES

Date	Staff					In-Patients	Out-Patient Visits	Staff Per Patient
	Medical Officers	Nurses	Enlisted	Civil. Maids	Total			
1946								
Feb	12	31	28	6	77	32	1798	2.4
Mar	12	34	27	7	80	52	2862	1.5
Apr	14	33	21	9	77	40	2324	1.9
May	12	33	28	9	82	41	2140	2.0
Jun	11	29	24	9	79	47	2033	1.7
Jul	10	21	23	6	60	71	2066	.8
Aug	11	16	30	7	64	58	2170	1.1
Sep	13	16	35	8	72	55	1961	1.3
Oct	11	16	33	5	65	67	2149	1.0
Nov	11	15	28	6	60	49	2104	1.2
Dec	9	15	30	6	60	50	1706	1.2
1947								
Jan	9	15	26	7	57	62	2122	.9
Feb	9	15	27	7	58	56	1760	1.0



TABLE 117  
DEPENDENTS SERVICE - SAN DIEGO

<u>Date</u>	Staff				<u>Average In- Patient</u>	<u>Out- Patient Visits</u>	<u>Staff Per In- Patient</u>	
	<u>Medical* Officers</u>	<u>Nurses</u>	<u>Enlisted &amp; Civilians</u>					<u>Total</u>
			<u>Enl.</u>	<u>Civ.</u>				
1946								
January	28	56	76	2	162	154	1.05	
February	28	56	71	8	163	139	1.17	
March	(27)	(52)	68	11	(158)	157	1.01	
April	(26)	(48)	65	22	(161)	143	1.12	
May	(24)	(44)	60	22	(150)	102	1.47	
June	(22)	(40)	55	20	(137)	113	1.21	
July	(21)	(36)	50	17	(124)	133	0.93	
August	(20)	30	46	17	(113)	123	0.92	
September	(19)	34	46	19	(118)	129	0.92	
October	18	33	45	19	115	100	1.15	
November	13	31	36	18	98	86	1.14	
December	12	30	46	18	105	67	1.57	
1947								
January	12	30	46	13	101	76	1.33	
February	12	30	40	13	95	95	0.99	
March	15	30	34	13	92	86	1.06	

\* No data was available on number of Medical Officers from March to September, 1946. Figures in parentheses are fairly reliable estimates.

TABLE 118

## DEPENDENTS SERVICE - NEWPORT

<u>Date</u>	<u>Staff</u>				<u>Average In- Patient</u>	<u>Out- Patient Visits</u>	<u>Staff Per In- Patient</u>
	<u>Medical Officers</u>	<u>Nurses</u>	<u>Enlisted &amp; Civilians</u>	<u>Total</u>			
1946							
January	4	2	6	12		778	
February	5	2	6	13		844	
March	4	2	6	12		1321	
April	5	2	6	13		1177	
May	5	2	5	12		1061	
June	5	2	4	11		1119	
July	4	2	4	10		1334	
August	4	1	3	8		1334	
September	5	1	3	9		1314	
October	4	1	4	9		1354	
November	5	1	4	10		1362	
December	5	1	4	10		1345	
1947							
January	6	2	4	12		1283	
February	6	5	3	14		1219	
March	6	5	7	18	20	1460	0.9
April	5	10	14	29	21	1729	1.4

















